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TABLE OF CONTENTS

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ADDRESS	OBITUARIES
THE BARONESS VON OLNHAUSEN. <i>By Alfred Worcester, M.D., Waltham, Mass.</i> 155	FREDERICK WADSWORTH HALSEY, M.D. 151
THE NEW ENGLAND SURGICAL SOCIETY	WILLIAM CASTERMAN MARON, M.D. 152
RECURRENT INGUINAL HERNIA. <i>By Ralph W. French, M.D., F.A.C.S., Fall River, Mass.</i> 155	
DISCUSSION OF DR. FRENCH'S PAPER 149	
ORIGINAL ARTICLES	MISCELLANY
FRacture AND DISLOCATION OF THE CERVICAL VERTEBRÆ WITHOUT PARALYSIS. REPORT OF A CASE. <i>By Willis E. Hartshorn, M.D., New Haven, Conn.</i> 141	DOMESTIC QUARANTINE AND VENEREAL DISEASE. 152
MEDICAL PROGRESS	A TRIBUTE TO THE SURGEON-IN-CHIEF OF THE HOSPITAL FOR RUPTURED AND CRIPPLED—DR. V. P. GIBNEY. 153
PROGRESS IN SURGERY. <i>By Edward H. Rusey, M.D., Waterville, Me.</i> 144	EXCERPTS FROM STATEMENTS MADE BY THE SURGEON-GENERAL OF THE UNITED STATES. 154
BOOK REVIEW	RÉSUMÉ OF COMMUNICABLE DISEASES, DECEMBER, 1921. 155
The Early Diagnosis of the Acute Abdomen. <i>By Zachary Cope, B.A., M.D., M.S. Lond., F.R.C.S. Eng.</i> 147	TUBERCULOSIS SCHOOLS FOR U. S. PUBLIC HEALTH SERVICE PHYSICIANS. 155
EDITORIALS	THE LEGISLATURE. 156
PNEUMONIA. 148	U. S. EXAMINATION FOR SPECIALIST IN CHILD HYGIENE. 158
THE ADDITION TO THE CHILDREN'S HOSPITAL, LONGWOOD AVENUE. 149	
NEWS ITEMS. 150	CORRESPONDENCE
MEDICAL NOTE. 151	THE TRAINING OF NURSES AND ATTENDANTS. <i>David H. Gibson, M.D.</i> 159
	MEDICAL LEGISLATION. <i>Samuel B. Woodward, M.D.</i> 160
	REGISTRY OF BONE SARCOMA. <i>E. A. Codman, M.D.</i> 161
	CONCERNING LEGISLATIVE PROTECTION. <i>J. R. Fowler, M.D.</i> 161
	LEGISLATIVE MATTERS. <i>Charles L. Upton, M.D.</i> 162
	INTEREST IN CO-OPERATIVE HEALTH PLANS FOR BOSTON. 162

Address.

THE BARONESS VON OLNHAUSEN.*

By ALFRED WORCESTER, M.D., WALTHAM, MASS.

NURSING is often spoken of as a new profession. So it is. But it is an old art. In this scientific age the importance of the art of nursing, and of the art of medical practice as well, is in danger of being forgotten. This is regrettable, but it is only the natural result of the wonderful advances of medical science during the last half century.

In my boyhood, I had the great advantage of the friendship of several unusually able family physicians. They knew nothing of the causation of diseases, and so almost nothing of their prevention.

Measured by present standards, these old physicians I knew and loved would be considered as ignorant practitioners. Well, what of it? What if they did know nothing of disease-producing germs and modern laboratory methods of diagnosis, they knew vastly more about their patients, and so far more of the healing art than is generally known today,—more's the pity.

They learned this art by apprenticeship and by experience—the only way the healing or any other art can be learned.

But tonight I am supposed to be speaking of nursing, to nurses and their friends. And I

have called attention to the change in the practice of medicine in order to explain the even greater change from old-time to modern nursing.

As the assistants of physicians and surgeons, nurses nowadays must know something of medical science. The more they know the better. But for their patients' sakes, it is even more important that they should be accomplished in the *Art of Nursing*.

Of course, there ought not to be any conflict between the nurse's devotion to her patient and her loyalty to the doctor. But I am afraid modern nurses are sometimes bothered by this dual duty: the old-time nurses never were. Their attitude to the doctor was generally tolerant, but not seldom it was that of ill-concealed hostility. Their whole devotion was to their patients. With them nursing was an art, not a science.

It is a misfortune that so little attention has been paid to what was excellent in the service of the old-time nurses. Undeserved ridicule and even obloquy has been heaped upon them as a class.

In the larger pauper hospitals of this country there may have been Sairy Gamps. It is true that in the Bellevue Hospital of New York sixty years ago the nurses were degraded women. But they were no worse than some of the training school nurses I have seen in one of our large city hospitals not many years ago. And yet in both cases such nurses were the rare exceptions.

The great majority of the old-timers were honest, hard-working, kind-hearted, sensible

*An address to the graduating class of the Waltham Training School for Nurses, June 25, 1919.

women. Older they all were than our modern white-capped nurses, and far more "sot," but not less worthy of their patients' loving gratitude.

In a previous paper I tried to portray one of these old family nurses, Mary K. Green, who is still gratefully remembered in this neighborhood. Tonight I shall try to describe another, a public service nurse, whose fame for that reason was far greater.

Mary Phinney was born just north of the Waltham-Lexington line February 3, 1818. She went to the old Kite End School, and afterwards to the Smith Academy in Waltham. Like Florence Nightingale, she knew every flower and insect and bird that could be found on the farm and in the woods. Like her, too, she was the first aid nurse for injured animals and neighbors. She lived until past thirty in the midst of plenty. But after her father's death, when his farm had to be sold and she was obliged to earn her own living, her artistic talent served her well. She became a designer of calicoes in a New Hampshire cotton factory. There she met a group of German republicans who, after the unsuccessful revolution in 1848, had been forced to leave their country. Among them was the Baron von Olnhäusen, whom she married in 1858. Theodore Parker said he was one of the most learned men he ever met. And Dr. Henry Ingersoll Bowditch described him as of serene and charming nature. He lived only two years after their marriage. And again Mary Phinney, now the Baroness von Olnhäusen, was thrown upon her own resources. For two years she slaved for her poor brother and his sickly family on an Illinois farm. In 1862, she volunteered as one of Dorothy Dix's war nurses. That was the beginning of her glorious career.

In *Adventures of An Army Nurse*, her nephew, James Phinney Munroe, gives us extracts from her diary and letters which vividly describe the tremendous obstacles that she surmounted. The hostility of the surgeons, the dishonesty and the inefficiency as well as the enmity of the hospital stewards, the awful lack of proper nourishment and materials would have conquered a less heroic soul.

Americans had profited nothing from the victory of Miss Nightingale over similar obstacles in the Crimean War. And it must also be confessed that not for ten years after the success of the Nightingale School of Nursing in England did we even attempt in this country the proper training of nurses. Undoubtedly in those years, our distrust of Great Britain prevented us from following Florence Nightingale's brilliant leadership. And when we now read in her biography that, while the cause of our Union was in greatest peril, she, in the employ of the British war office, was planning the nursing service for the British forces in their projected attack on our Canadian border, we

realize that our distrust was fully warranted. But after the successful Arbitration of the Alabama claims, and the resumption of friendly relations with our mother country, we began, in the early seventies, to follow Miss Nightingale's advice in starting our schools for nurses.

In this great reform the Baroness von Olnhäusen had no part. In fact, she was displaced by it. When I was in college and first visited the Massachusetts General Hospital, as was the custom of students who were intending to enter the medical school, she was the superintendent of nurses. Miss Linda Richards, her successor, gives in her *Reminiscences* a graphic description of the nursing conditions there when she took charge. One illustration will suffice, at any rate for our hospital staff and trustees who now demand several months' longer terms of service for our head nurses. Under the Baroness, the head nurses served only for one day. Then they went back into the diet kitchens for a day; then to the washing and rolling of bandages; the next day they served as night watchers; then as juniors in the wards; and, after a week of such rotation, they had another twenty-four hours of head nurseship. No wonder there was confusion instead of effective team work. And yet, as I hope to show, Mary Phinney was one of the greatest nurses America has ever produced. She asked nothing of her subordinates that she herself would not willingly have done. In her estimate, all the different services were of equal importance for the welfare of her patients, which was ever her first and only consideration. Indeed, her devotion was so intense that it is safe to say no nurse who has ever lived, not even Florence Nightingale herself, was more beloved by her patients.

By contrasting the great services of these two noble women, the difference between old-time and modern nursing is made plain. Miss Nightingale was not only far better educated, she was also one of the world's greatest organizers. She first brought the British war office to adopt her reorganization of army nursing; then she reformed the pauper hospitals of England, and finally the public hospitals of the whole civilized world, by the influence of the nursing school she established and guided at St. Thomas's. The secret of her great power in effecting these reforms is to be found in the fact that, before beginning her life work, she herself was thoroughly trained in the nursing schools of the Roman Catholics in Paris and Bruges and also in the Lutheran School at Kaiserswerth.

Mary Phinney, on the other hand, was absolutely untrained, and she was also wholly ignorant of the history of nursing and of the great traditions of the European schools. She was not an organizer. And she was a poor executive. Not disciplined herself, she could not discipline others. Only when surrounded by willing workers, somewhat like herself in

their devotion, was any team work possible for her.

As her biographer well says of that stage in her career, "her breezy cheeriness, her kind words to every patient, her untiring efforts to keep them buoyed up and entertained, were as conspicuous as was her scrupulous attention to cleanliness and her wonderful skill in the treatment of wounds." That is a good description of excellent nursing, whether of the past or of the present. No wonder she was beloved by her patients.

But you will now be asking, how did she acquire this wonderful skill of hand, and this power to bring her heart into such effective action? This is the answer: she worked with tremendous will at every task she undertook; she aimed high—at perfection. Without thought of self, she gave forth her best; and the best of every woman is her motherliness.

When she began her Army Nursing in the Mansion House at Alexandria no room was provided for her, and only occasionally could she find a chance to sleep on the floor of another nurse's chamber. Dorothy Dix's volunteer nurses, women of distinctly better class, were not wanted by the surgeons. They tried in every way to freeze them out. But her good heart and untiring zeal soon won their respect, and in six months she was trusted to put up in splints even the worst compound fractures. Indeed, she had this to do for one of the surgeons who came back wounded. He demanded that she should do it, and his surgeon comrades looked on admiringly. In one of her letters she speaks of the young Major Henry L. Higginson as one of her patients. Often days went by with no visits from any surgeon to her ward. Before her first year was passed she nearly died of epidemic dysentery, but by September of 1863 she was again on duty as chief nurse of an Army Hospital at Morehead City, N. C. Here, besides the old obstacles of insufficient supplies, she had the refugee Negroes to contend with. In the following year came the yellow fever of which the surgeon-in-chief died, in spite of her unremitting care. Soon she, too, was stricken and nearly died. But as soon as able she returned to her post.

"Two hundred wounded just arrived," she writes in her diary, "and I the only wound-dresser in the ward." And in a letter to her friends she wrote: "Perhaps you will be glad to know that the medical director of the Department of North Carolina sent me word that his nine surgeons, after examining those wounds, said they had never seen wounds so well dressed and such bad wounds so soon getting well; and for himself he said I was the best wound-dresser in the country." And later she writes: "We have not lost a man, though we had such terrible cases."

No wonder that the chief surgeon's testimonial was heartily endorsed by the Medical

Director. This is what he said: "Not one of the nurses whom I have known or heard of is better entitled to eminent and substantial notice than is Mrs. Mary von Olnhausen of Lexington—Her whole soul has been in the work. She very early acquired a marvellous dexterity in the management of the wounded. Thus, with her wonderful physical endurance, she was able to do more good than any nurse I ever knew. Soldiers who owe their lives to her care and skilful attention are scattered, now, over nearly all the Northern States. They will remember her with gratitude. I presume that is all she will wish for." The surgeon was right in his presumption. For, as he said, she was ambitious for neither fame or notoriety. And, as soon as the war was over, back she went to the Illinois farm to drudge for her poor brother and his now motherless children. This she did for five years.

But when the Franco-Prussian War began in 1870, she seemed to hear from afar the cries of the wounded. Go she must, and armed with highest credentials from our Governor and Surgeon-General, and with strongest possible recommendations from the American Association for Relief of Misery of Battle Fields (the precursor of our American Red Cross), Mary von Olnhausen, now fifty-two years old, went to Germany. It must be remembered that fifty years ago American as well as English sympathies were almost entirely with Prussia. Louis Napoleon was our *bête noir*.

Most unfortunately she lost her trunk and her credentials, and so for several months she could not find work or even get near the front. A less dauntless soul would have given up in despair. But, for her, obstacles were always surmountable. And soon her diary tells us of hard journeys in army wagons in Château Thierry, Rheims, Neaux Lagny and Epernay, Corbeil and Orleans. How familiar sound these places now and how familiar, too, her descriptions of war destructions! Unable at first to speak either German or French, crowded out by the Catholic sisters or Protestant deaconesses, and even by the English nurses, it was only when she chanced upon the Knights of St. John—of the old order of Knights Hospitalers—that she found work in the Hospice at Vendôme. There for two months she had her hands full. Besides the wounded, there were typhoid and smallpox cases to care for. And worst of all, before the patients were fit to leave their beds, came the orders to move them back into Germany, as the army was evacuating France. That was a terrible journey—and after it Mary von Olnhausen's war service was ended. The Iron Cross and the Order of Merit which she won, and the testimonials given her by the German war office, were not rated then as now. After her two years' stay with her husband's sister in their ancestral Saxon home, she came back to America, our most honored

war nurse. Then it was that for a year or two she had charge of the Nursing Service in the Massachusetts General Hospital, which I have already described.

For several years afterwards she was the Superintendent of a Maternity Asylum on Staten Island. That was a happier and more successful service. But she finally came into conflict with the managers, and her nursing career was finished.

She then, in her indomitable independence, was unwilling to accept even the hospitality of her near relatives, and began working at embroidery. Again her artistic talent served her in good stead. For in this, as in everything else, she succeeded. Her work was exquisite, and she was most happy in it until she died of an apoplexy, in Boston, April 12, 1902.

Her body in its flag-draped coffin lies buried in Mount Auburn. But nurses and all who pray for the advance of the Art of Nursing never ought to forget the great soul of Mary Phinney, the Baroness von Olnhausen.

The New England Surgical Society.

RECURRENT INGUINAL HERNIA.

BY RALPH W. FRENCH, M.D., F.A.C.S., FALL RIVER, MASS.

MUCH has been written on the subject of herniotomy and many methods varying in detail have been described, all designed to cure the existing hernia and prevent a recurrence. This paper is designed to point out the usual sites of recurrence after operation for inguinal hernia and to emphasize the steps in the operation which will best fortify these locations.

Andrews¹ states that at least one in every fifteen or twenty of all males in every community is ineligible, by having a hernia, for service in the army, navy, police or fire department. The frequency with which hernia occurs in normal individuals may also be indicated by Lauffer's² report, that in examining a large number of men for factory work, when a physical examination was required, three per cent. of those offering themselves for work had a well developed hernia and that fourteen per cent. had an incipient hernia. Ninety-two per cent. were indirect and the other eight were direct. Nearly twice as many of these were on the right side as on the left side.

It is significant that more cases present themselves for operative treatment during the years of active work, that is between the ages of twenty and fifty. With the adoption of the Bassini operation, published in 1886, the results of hernia operations became very much better, and since then the Bassini operation, with or without modifications, has been used extensively. Although the modifications have been numer-



FIG. 1. Represents a recurrent direct hernia which may result from too tight sutures between the internal oblique muscle and Poupart's ligament.

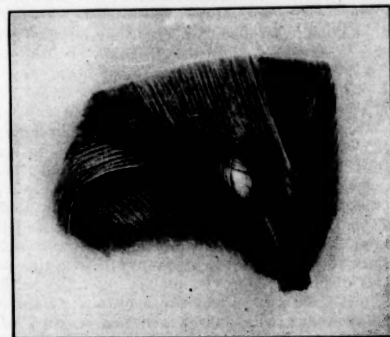


FIG. 2. Shows the result of failure to place the first stitch between the internal and Poupart's ligament sufficiently low.



FIG. 3. Represents a recurrence occasionally seen through the internal ring.

ous, none has altered the underlying principles of removing the sac, obliterating the tract and restoring the layers of the abdominal wall to approach the normal.

The regions in which a recurrence is most likely to appear are shown in the accompanying drawings. Figure I represents a recurrent, direct hernia which may result from too tight sutures between the conjoined tendon or internal oblique and Poupart's ligament. Figure II shows the result of failure to place the first stitch between the internal oblique and Poupart's ligament low enough. And Figure III represents a recurrence occasionally seen through the internal ring.

Masson³ reports less than one per cent. recurrences at the Mayo Clinic in over seven thousand cases. Coley⁴ reports 0.57 per cent. recurrences in oblique inguinal hernias in male children, 0.15 per cent. in female children, and 3.5 per cent. in adults. In the direct variety he reports no recurrences in thirty-three cases. Other figures vary from one per cent. to five per cent. recurrences for all types of inguinal hernias.

Bloodgood,⁵ in the *Johns Hopkins Hospital Reports*, studied 500 post-operative cases of hernia and gave as the chief cause of recurrence the obliteration of the conjoined tendon. This emphasizes the fact that the function of the sutures should be to bring the tissues into approximation for union without strangulation and should not take any mechanical strain which the tissues themselves are not capable of holding. The point is perhaps more graphically expressed by Andrews when he queries, "Do we have to use a steel hawser to hitch a horse to a post, or can we hitch a horse to a post with a cobweb?" If this rule were strictly adhered to, it would seem that the objections to the Bassini operation made by some, that the tension of the conjoined tendon to Poupart's ligament causes pressure atrophy, would be obviated. And the possibility of the conjoined tendon splitting and resulting in a direct hernia would be almost negligible.

In looking up the results obtained in 300 inguinal hernia cases which were operated upon at the Truesdale Clinic more than six months ago, I found that there was a recurrence of five, or 1.7 per cent. Three of the recurrences were in cases that had a direct hernia originally and the recurrence was of the direct type. The other two were originally indirect and in one the recurrence was direct and in the other indirect.

Several causes of recurrence, other than violence soon after operation, have been generally discussed. Sepsis, which is considered by most writers as a negligible factor, may be of more importance than we realize. Sepsis of some degree can occur in a wound while betraying very little evidence of its presence and will often result in the yielding of sutures. And

here I wish to reiterate the often made plea for the gentle handling of tissues in this operation when performed under a general anesthetic. Trauma lessens the resistance to infection, and the possibility of an accumulation of serum under the skin is greater if there is much trauma. A small amount of serum under a scar should be considered as a low grade of sepsis. Imperfect hemostasis may account for such an accumulation of serum. And as this condition affords an excellent culture medium, no wound should be closed until hemostasis is complete, if the best results are to be expected.

Another cause of recurrence may be attributed to nerve injury with resulting atrophy of the tissues. It is not uncommon to find that the recurrent hernia is a direct one when the first hernia was indirect. This is usually associated with an atrophied condition of the internal oblique which may be due to nerve injury or more probably to too much tension from sutures. Failure to suture the conjoined tendon low enough to Poupart's ligament so that no opening is left behind the external ring is another source of recurrence.

A saddle bag, bilocular or pantaloon hernia may be present, which represents a combined hernia. If this fact is not recognized and the sac appearing as an indirect hernia only is removed, it is obvious that trouble may be expected later from the other part of the hernia. For if the internal oblique is not strong and provision has not been made to fortify the area against a direct hernia, a bulging through Hesselbach's triangle may be expected within a few months.

Having isolated an indirect hernial sac, how often does the surgeon examine to ascertain the possible presence of a beginning direct hernia? It is fair to say that this simple precaution is seldom taken. When one is found it is usually possible, according to Torek,⁶ to convert the direct sac into an indirect one by pushing the deep epigastric vessels toward the middle line while pulling the peritoneum outward. In this way the cut edges of the sac may then be closed by a running stitch as in any direct hernia. When a small, direct hernia also exists at the time of operation for a large indirect hernia, the direct one is likely to appear later; for if much tension is added to the layers employed in the Bassini operation, under the cord, the direct hernia is soon liable to make itself evident. Therefore, why not know, during the operation, that a combined hernia exists, and fortify this region against it?

Special difficulties are encountered in cases where the tissues of the internal oblique are thin, soft and relaxed. This is often found to be the condition when a truss has been worn for many years. Another problem is encountered when the internal ring has stretched

downward so that it lies directly in back of the external ring. The sliding hernia also presents difficulties because of the unusually large internal ring with the surrounding tissues greatly stretched. In these operations an additional support may be obtained by suturing a piece of the rectus fascia across the relaxed tissues.

Usually the more times that a hernia has been operated upon the greater are the difficulties encountered. Among elderly men whose tissues are thin and relaxed it becomes a necessity in rare instances to remove the testicle and cord entirely in order to effect a cure. In such instances closure of the wound is simple; for the wall is closed as in any incisional hernia.

Operations for a recurrent inguinal hernia must of necessity differ considerably, depending upon the particular type of recurrence. Any method would be ideal as Andrews states¹ which supplies a well nourished flap of such ample size that it can be brought over the weak spot without tension. It is interesting to note the unanimity with which this idea has been felt; and has been manifested by the large number of ingenious methods which have been suggested for the purpose.

The essentials in an operation for recurrent hernia are the same as for the original hernia, that is, the removal of the sac which obliterates the tract and the restoration of the layers to approach the normal. In order to have reasonable assurance of success all scar tissue should be removed, the fascia laid bare of fat and mobilized, dissecting it sufficiently to allow adequate apposition with Poupart's ligament without tension. This same technique should be carried out in dealing with the lower border of the internal oblique. The sac should then be isolated and removed completely. The nerves in the region of the inguinal canal, if found intact, should be preserved with care. Then free use must be made of the adjacent muscles and fascia to repair the deficient portions of the abdominal wall.

Transplants or the introduction of foreign substances such as silver wire are rarely if ever needed and have not been used in any of our cases. The Bassini technique can usually be carried out, though occasionally it is necessary to leave the cord outside of the external oblique, as in the Halstead operation. Whenever it is possible we prefer the modification of the Bassini suggested by Andrews,² which differs from it in that the upper segment of the flap of the external oblique aponeurosis is drawn down behind the spermatic cord while the lower flap is drawn up in front of it, the two flaps then lapping or imbricating, the cord is included between them.

Occasionally it may be found to be advantageous to flex the thigh during the sewing-up

process, as recently suggested by Lyle,³ and to keep the thighs flexed during the first week of convalescence. This procedure relaxes Poupart's ligament, the conjoined tendon and the adjacent tissues thereby insuring added relaxation during the healing process.

We allow most of our cases, whether of the recurrent type or not, to get up on the tenth or twelfth day. The large or difficult hernias are kept in bed for two weeks. Light work is permitted in four to six weeks and heavy work in three to four months.

SUMMARY.

The causes of the recurrence of an inguinal hernia may be summarized as follows: (1) tension of the sutures; (2) impaired innervation; (3) infection; (4) failure to approximate the internal oblique and Poupart's ligament sufficiently low; (5) leaving the internal ring too large; (6) failure to recognize a direct hernia during an operation for the indirect type.

Each case of recurrent hernia presents its own problem. Its cure depends upon the appropriate utilization of structures available.

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- ⁵ Bloodgood: *Johns Hopkins Hosp. Reports*, V, 17, p. 277.
- ⁶ Tork: *Ann. Surg.*, 1919, XIX, 658.
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- ⁸ Lyle: *Surg., Gyn., and Obstet.*, November, 1920, p. 529.

DISCUSSION OF DR. FRENCH'S PAPER ON "RECURRENT INGUINAL HERNIA."

DR. DANIEL F. JONES, Boston: This seems to me to be a very important paper and of great interest to all of us. I have done none but the recurrent herniae at the Massachusetts General Hospital for some years. This has led me to believe that a hernia operation is a serious one from the point of view of the patient. Not only has he wasted much time if the operation is a failure, and that is important to most patients, but more important still is the fact that the tissue making up the canal is so injured by the operation or by sepsis that it is impossible to repair it properly.

Dr. French has mentioned many important reasons for recurrences but did not, I think, mention the fact that a direct hernia is frequently overlooked and occasionally an attempt made to cure an indirect, when the lesion is a direct hernia. I have come to this conclusion, because so many of the recurrent herniae which were indirect, are direct.

Failure to close the transversalis fascia close about the cord as pointed out by Moscovitz is another reason for recurrence. Too vigorous an effort to get all the sac separates the fibres of the transversalis fascia and leaves a weak place when the sac is tied off. An effort should be made to catch the fibres of the transversalis fascia and pull them together when the sac is tied off.

Any bulging of the canal below the deep epigastric artery should be remedied by a plication of the transversalis fascia; even with marked bulging it is, I believe, unnecessary to open the peritoneum.

Another important point in repairing a hernia is to suture the conjoined tendon at the lowest possible

point on Poupart's ligament. This helps to keep the area flat and to prevent any bulging which gives a hernia a start.

The operation for hernia is much more serious than it is generally considered. When we consider that many are done on working men who are having the operation done at considerable expense of time, every effort should be made to give them the best possible result. The more difficult types should be done by the more experienced surgeons.

DR. CHARLES A. PORTER, Boston: There is a joke that Dr. _____ of _____ found that the senior men had the most recurrences and the younger men the least.

DR. SAMUEL W. GODDARD, Brockton: I would like to emphasize another point, and that is, the importance of getting equal tension on all sutures, so that when pressure is exerted from within, the pressure may come against them all as a whole, equally, and not on a few.

DR. DAVID CHEEVER, Boston: I have listened with the greatest interest to Dr. French's paper and I think he is to be congratulated on his excellent statistics from the Fall River Clinic. His cases include some operated on as recently as six months ago, and while I do not wish to be pessimistic, I must say that few of the recurrences that have come under my observation have occurred within six months, and I suppose therefore that there are bound to be more among his cases later on. Most of the recurrences in my own experience have come after two or three years.

Especial emphasis has been placed both by Dr. French and Dr. Jones on the importance of painstaking care in technique of operating and of a knowledge of regional anatomy, and I am glad to take this opportunity, as I wished to also at the close of Dr. Lahey's paper, reporting 20-odd per cent. of accidental sections of the musculospiral nerve in dissections of the neck, from the City Hospital Clinic, to make a strong plea for the necessity of an accurate familiarity with anatomy. There has been no more harmful doctrine promulgated by a certain group of surgeons than that a knowledge of anatomy is relatively unimportant in surgery, and that a surgeon can learn his anatomy at the operating table. Doubtless many of these cases of accidental nerve injury were at the hands of junior men, and while some such injuries are inevitable the liability to them is much increased if the operator is not absolutely familiar with the anatomy involved. In the same way, recurrences after hernia operations may sometimes be explained on similar grounds. But you cannot make a silk purse out of a sow's ear, and if you are not dealing with good, sound tissues, the percentage of good results will be much smaller, and I have no doubt that in most of the hernias that Dr. French and Dr. Truesdale have operated upon, with subsequent recurrence, there has been little to work with.

Going back to the conception of anatomy as the great underlying factor in the success of operations for hernia, the operator should have very definite principles and ideals for every step of the operation: For instance, in the treatment of the sac in indirect hernia he should not ligate or cut away the sac until he has carried out the dissection of its neck to the level of the deep epigastric artery. The vessel should be clearly demonstrated, and the neck of the sac transfixed and ligated at that level at least, or higher, if possible. The artery lies just extraperitoneally, and after the ligation and removal of the sac, there should not even be a dimple left, if it could be looked at from the intra-abdominal aspect.

I agree with Dr. Jones about the folly of invariably opening the sac in direct hernias. Too often

the sac is operated and it is found on attempting suture that there is really not sac enough to work away. What has been done, therefore, is practically useless, and some form of plication is the best thing to do. Incidentally, the presence of the urinary bladder should be suspected in every direct hernia and it is occasionally accidentally opened, and this accident would be avoided if the peritoneal protrusion is plicated rather than opened.

Concerning the transplantation of the cord outside the external oblique and the covering of the cord with the lower segment of the aponeurosis, that seems to me unnecessary. It is apt to be too much compressed by this flap and a wide imbrication and adhesion of the apposed surfaces is not obtained unless the lower flap is smoothly sutured to the upper segment of the aponeurosis, whose edge has been brought down to Poupart's ligament, without effort to cover in the cord. The latter will lie just as comfortably between the layers of the superficial fascia, and I believe that it is just as safe there from trauma as it would be in its deeper position. I think this is the operation of choice in primary operations for hernia when you are dealing with poor tissues, and the best operation when you are dealing with most recurrent hernias.

DR. RALPH W. FRENCH, Fall River: I am glad Dr. Jones brought out the point about the transversalis fascia which will add security to the procedure. Herniotomy is a most interesting subject. Each recurrent hernia is a little different from the last one, and this fact makes each case a separate interesting problem.

Original Article.

FRACTURE AND DISLOCATION OF THE CERVICAL VERTEBRÆ WITHOUT PARALYSIS. REPORT OF A CASE.

By WILLIS E. HARTSHORN, M.D., NEW HAVEN, CONN.

INJURIES to the cervical vertebrae are of comparatively frequent occurrence. They result fatally in a rather large percentage of the cases. Owing to the fact that the spinal canal in the cervical region is somewhat larger than in other portions of the column, there is a greater range of mobility to the cord in this region. It is for this reason that a certain number of these cases, even when associated with fracture and dislocation of the bony framework, do not cause the death of the patient. Occasionally, comparatively few symptoms suggesting pressure on the cord are present, at least in the earlier stages following injury.

A certain similarity exists between fractures of the skull and fractures of the vertebrae. Both the brain and the spinal cord are encased in a bony, protective framework and constitute essential parts of the same system.

Broadly speaking, two main divisions may be considered: the type with paralysis and the type without paralysis.

Injuries to the spinal cord might be classed as follows: (1) Concussion. Associated with this may be a temporary paralysis. (2) Trauma, with intraneural or spinal hemorrhages. In



FIG. 1



FIG. 2



FIG. 4



FIG. 4



FIG. 4

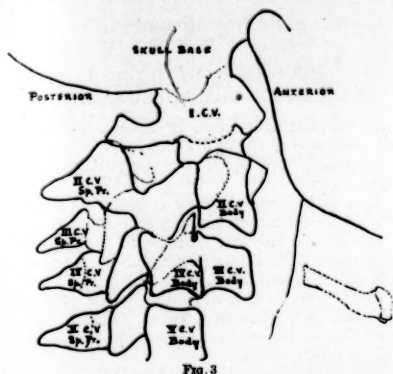


FIG. 3

this case the paralysis may be present for a considerable period in certain groups of muscles, and gradually disappear. (3) Injuries to the cord from fragments of the bony framework, with resulting pressure symptoms or laceration of the cord with destruction of tissue. (4) Pressure on the cord due to dislocation of the vertebrae without fracture. (5) Fracture and dislocation of the vertebrae without injury to the cord. (6) Compression frac-



FIG. 5

tures of the bodies of the vertebrae. Any of these lesions may, if recovery takes place, present a later stage associated with painful neuralgias due to pressure from scars or callus formation and to actual deformities which have been typed under the general heading, "Kummel's Disease," and may present themselves as an actual kyphosis at the focus of injury to the bodies of the vertebrae.

The prognosis depends upon the degree of paralysis. If this is extensive, even with operative interference the outlook is very poor. If not extensive, recovery is more probable. Removal of bony fragments pressing on the cord is always advisable when moderate grades of paralysis are present. If dislocation alone is noted, without fracture, but with paralysis of greater or less degree, it is advisable to attempt extension of a rather forcible character by manipulation. A number of cases have been reported in which reduction has been readily accomplished without accident. The greatest care must be exercised while making the attempt, and all unnecessary trauma avoided. The attendant risks should be carefully explained to the patient.

The following case, from the writer's service at the New Haven Hospital, is presented as it combines the rather unusual features of a severe fracture and dislocation, without paralysis.

Name—E. M. Age—20. Admission Number—63136. Occupation—Soldier. Admitted August 11th, 1917. Discharged November 2nd, 1917. Diagnosis—Comminuted fracture of the second and third cervical vertebrae. Anterior dislocation of the first, second and third. Complaint—Multiple contusions of head, neck and left shoulder. Present Illness—Patient was hit by locomotive while walking on railroad tracks. Was brought to hospital in deep shock.

Physical Examination: Head—There are lacerated wounds of the scalp over the parietal and occipital region. No depression fracture noted. Eyes are normal, respond to light and accommodation. Jaws are intact. Uvula is in midline. Cervical Region—Swollen and painful, posteriorly. Marked deformity. Thorax—Clavicles are intact. No fractures of the ribs. No injuries to lungs. Right Upper Extremity—Normal movements. Sensory reactions undisturbed. Left Upper Extremity—Very marked swelling over deltoid region, with severe lacerations. Patient is able to move arm to moderate degree. Rotation is without pain. Abduction limited to 90°. No crepitus. Suggests hematoma beneath skin. Head of humerus apparently in position. Extremity is not paralyzed. Abdomen—No distention; no rigidity; reflexes undisturbed. Right Lower Extremity—No paralysis. Left Lower Extremity—No paralysis.

August 16th, 1917—No paralysis of extremities. A number of small vesicles on the chin suggest atrophic changes. Pupils are equal and respond to light and accommodation. Sphincters intact. Marked fullness over cervical region posteriorly. Head lies in same axis as trunk.

Dr. Max Mailhouse, Neurologist, August 18, 1917.—Apparently no paralysis in right shoulder muscles, arm, forearm or hand. Muscles that elevate shoulder have lost power on left side. Pronounced herpetic eruption on neck. Sympathetic reacts well on both sides. Too high for sympathetic involvement. No involvement of central canal. Can move lower extremities. Plantar reflexes present, but not lively. Muscle sense normal. Knee-jerks present, but not lively. Achilles-jerk present on both sides. No incontinence. Abdominal reflexes present. Better on right than on left. Takes a good deal of force to bring them out. Sensations normal here. Grip good in both hands.

August 26th, 1917.—No paralysis. On palpation, the deformity in the posterior cervical region is not marked. September 9th, 1917.—Tender point over mid-cervical spine, but no swelling. No paralysis. Motion of left shoulder gradually returning. September 14th, 1917.—Patient is able to sit up on back-rest. November 2nd, 1917.—Discharged. Has been up and around the ward for several weeks. Can walk without difficulty. Still has some paresis of left deltoid, with atrophy. Neck not absolutely rigid. Wears brace for neck.

REPORT OF X-RAY EXAMINATIONS.

August 15th, 1917.—No dislocation of the head of the humerus. There is, however, separation of the left clavicular-acromion juncture. August 16th, 1917.—No dislocation of the head of the left humerus. Forward displacement of the atlas. Forward displacement and fracture of the second and third cervical vertebrae. The fracture is semi-longitudinal, apparently, through the arches of the vertebrae and also through the laminae. The spinous processes are approximately in position. October 24th, 1917.—X-rays taken as the patient was about to be discharged, show no change in the last examination. Detailed structure is perhaps a little clearer. Figures one and two show radiographs. Figure three shows x-ray tracing.

Treatment—Advisability of forcible extension considered by consultants, but discarded as dangerous. Moderate traction applied in order to secure proper splinting of head and neck. Extension carried over head of bed. Moderate rigidity of head and neck secured by sandbags. On leaving bed, application of mechanical support, as noted in Figures four and five.

Six months after discharge the patient reported for examination, with the following findings: No paralysis; no secondary neuralgias; marked stiffness of neck.

Medical Progress.

PROGRESS IN SURGERY.

By EDWARD H. RUSLEY, M.D., WATERVILLE, ME.

LILIENTHAL describes, in *Annals of Surgery* for September, 1921, his extrapleural resection and plastic operation for carcinoma of the oesophagus.

This is an entirely new operative procedure of a decidedly major character and has as a part of its technic the introduction of a rubber tube reinforced with a large skin flap to replace the resected diseased area.

The article is well illustrated with x-ray photographs of a successful case. It also contains the histories of four other cases operated on by this method.

The author concludes from his experience that transpleural resection of the oesophagus has a forbidding mortality: that fatal infection follows the primary opening of the oesophagus within the mediastinum; that it is feasible to make an extra-pleural exposure of the posterior mediastinum large enough to permit the operator to see clearly and to work safely with both hands in the wound; that resection of the oesophagus in the posterior mediastinum can be done by dividing the operation into two stages; at the first the oesophagus is freed from its attachments and the mediastinum is sealed; at the second, ten to fourteen days later, the resection is performed.

The article contains a complete bibliography on this subject.

HIGH TRACHEOTOMY AND OTHER ERRORS THE CHIEF CAUSES OF CHRONIC LARYNGEAL STENOSIS.

JACKSON, CHEVALIER, (*Surgery, Gynecology and Obstetrics*, May, 1921) writes as follows:

1. The most frequent cause of chronic laryngeal stenosis is high tracheotomy.

2. While in a given case no one has any right to say that the operation that saved that patient's life was an unjustifiable one; yet, equally rapid methods being available, high tracheotomy should not be taught.

3. The classic distinction between a high and low tracheotomy with reference to the isthmus of the thyroid gland is a relic of the days when too much respect was had for the thyroid gland, or at least for its isthmus, and the distinction should be abandoned. The vitally important matter of where the trachea should be incised should not depend upon the negligible isthmus. There should be taught only one tracheotomy and that should be low.

4. The trachea should always be incised lower than the first ring except in those rare cases in which laryngoptosis renders this impossible without entering the anterior mediastinum.

5. The cricoid cartilage should never be cut unless laryngoptosis places all the rings of the trachea below the upper border of the manu-

brum, which would require entering the medias-tinum if the rule were to be followed.

6. The tracheotomic causes contributing to chronic laryngeal stenosis are:

- a. High tracheotomy.
- b. Hasty operation.
- c. Attempts at general anaesthesia.
- d. Cutting of the cricoid cartilage.
- e. Hacking the trachea by several incisions instead of one.
- f. Denuding the tracheal cartilages of perichondrium with resultant necrosis.
- g. Suturing the wound.
- h. Prolonged wearing of a cannula that is of improper size, shape, or material, such as rubber or aluminum, or one with a fenestra, or one without a pilot.

i. Neglect of proper after-care. The keynote of the after-care should be that it is a plumber's job; the "pipes," natural and instrumental, must at all times be kept clear.

7. If in an emergency a high incision of the trachea has been made, a cannula should not be worn in it. As soon as the patient's breathing has been resumed a low incision should be made and the cannula should be inserted therein.

8. Going deeper, the fundamental cause of so many cases of chronic laryngeal stenosis lies in the faulty teaching in the surgical textbooks. The eminent surgeons who write textbooks would not do a tracheotomy through the larynx to avoid the isthmus of the thyroid gland, or because of haste; but eminent surgeons are not often at hand when emergency tracheotomies are required. These operations are usually postponed until respiration has ceased. If not already stopped the practitioner promptly stops it by attempting to give a general anaesthetic.

SURGICAL APPROACH TO THE SPHENO-PALATINE GANGLION.

Frazier in *Annals of Surgery* for September, 1921, describes an ingenious and new approach to the sphenopalatine ganglion.

The steps of the operation are as follows:

1. The incision has been designed with due regard for its cosmetic effect and to avoid important branches of the facial nerve. There are three limbs, one straight, in the direction of the zygoma, and two curved, following the lines of the supra- and infra-orbital ridges, with careful apposition of the margins of the wound the healed scar is quite inconspicuous. The branches to the orbicularis palpebrarum and the occipitofrontalis have not been disturbed.

2. Upon reflection of triangular flaps the malar bone is exposed and with a Gigli saw three sections of the bone are made: (1) through the frontal process; (2) through the maxillary process, and (3) through the zygomatic process. To make sections 1 and 2, the Gigli saw is passed through the sphenomaxillary fissure. At section 3 the zygomatic process is sawed only partly through, the outer shell and the periosteum be-

ing left intact. Thus an attachment is conserved which prevents any dislodgment of the malar bone when replaced at the completion of the operation.

3. The malar bone reflected backward at once exposes to view the zygomatic fossa and its areolar tissue. One sees in the anterior portion of the wound the external aspect of the orbit.

4. A clearing of the contents of the zygomatic fossa is made now to expose the pterygoid plate. This is accomplished by following closely the surface of the posterior wall of the antrum and displacing backwards and downwards the areolar tissue and the temporal muscle. Before the pterygoid plate is exposed to view the internal pterygoid muscle must be detached.

5. With rongeur forceps a portion of the pterygoid plate is removed and the contents of the sphenomaxillary fossa exposed. To find the sphenopalatine ganglion one should expose first the maxillary division, as it enters the orbit through the sphenomaxillary fissure, and follow it up to the ganglion. The ganglion itself is deeply placed in the sphenomaxillary fossa, close to the sphenopalatine foramen. Surrounded by fat, it is not readily seen, hence the necessity of following the course of the maxillary division as a guide.

Throughout the operation one does not see the internal maxillary artery. One might have anticipated troublesome hemorrhage from this source, but such is not the case. The only arterial trunk that one sees is the continuation of the internal maxillary artery in the infraorbital artery. The space in which one works is comparable in size to that in the approach to the Gasserian ganglion and I have found my illuminated retractor—so satisfactory in the Gasserian ganglion operation—amply illuminates the field.

TRANS-ORBITAL PUNCTURE OF THE GASSERIAN GANGLION.

VAN ALLEN, C. M. (*Annals of Surgery*, November, 1921.)

This author presents a very thorough and interesting treatise on this interesting subject. He outlines indications for the use of this particular operation and describes the technic of Harris and Härtel. He takes up the anatomy in detail and graphically describes the introduction of the needle from without through the inner canthus of the eye along the orbital wall to the Gasserian ganglion. He uses a Patrick cranial needle 10 cm. in length and 1½ mm. in diameter equipped with a closely fitting stylet.

There are several pages of drawings made from anatomical subjects showing the depth of the ganglion from the inner canthus of the eye and the general direction which the needle should take, also illustrations of five clinical cases on which this technic was successfully carried out. These were largely extensive lesions of the cheek in patients who were unable to take

a general anaesthetic and in whom a purely local anaesthetic was not feasible.

The author makes the following statement in conclusion:

"It is evident that whatever injury is inflicted upon the root of the ganglion by the injection of alcohol will be shared to a less extent by neighboring nerves. This is true, no matter by what approach or technic the needle is entered, and transorbital puncture is no exception. Accordingly, until some means shall have been discovered of preventing this widespread diffusion of the alcohol, we cannot at all recommend the puncture in the therapy of trigeminal neuralgia.

"Other possibilities for the employment of the technic suggest themselves. It affords a method of withdrawing cerebro-spinal fluid directly from the basilar cistern. Wider experience may justify an attempt to use this route for therapeutic applications to the central nervous system. The effect of air injections in the x-ray diagnosis of intracranial disorders is likewise worthy of investigation.

"But in the meanwhile the results of this work, both anatomical and clinical, lead us to believe that transorbital puncture of the Gasserian ganglion furnishes a relatively simple means of securing block anaesthesia for operations in the territory supplied by the trigeminus, fully justified in cases where general anaesthesia is contraindicated."

CAUSATION AND AVOIDANCE OF CEREBRAL DISTURBANCE IN LIGATION OF THE COMMON CAROTID ARTERY.

Freeman in *Annals of Surgery* for September, 1921, writes an interesting article on the causation and avoidance of cerebral disturbance in ligation of the common carotid artery.

He discusses the former theories that this condition was due to anaemia of the brain followed by softening, and then seems to prove by his argument that this theory can not longer be held as correct. He proposes an apparently more rational theory, recently emphasized by Perthes, which indicates that thrombosis at the point of ligation followed by embolism is the real cause of cerebral symptoms. This accounts for the sudden onset of cerebral symptoms, and the greater or less interval which precedes them.

The preponderance of cases occurring after middle life is explained by the greater brittleness of the inner coat of the artery.

In order to avoid injury to the intima, Freeman ligates his artery with a strip of fascia lata and only ties it tight enough to occlude the lumen of the vessel, but avoids crushing the intima.

SOME RESEARCHES ON THE PERIARTERIAL SYMPATHETICS.

LERICHE, RENE (*Annals of Surgery*, October, 1921.)

The author presents a very interesting article on the nerve supply of the various coats of ar-

teries, and has worked out an operation which is applicable in certain forms of trophic disturbances. He cuts down upon the artery and carefully decorticates it, thus severing the sympathetic nerve control which produces a dilatation of the arterial wall and hence improves the circulation. He shows two or three remarkable photographs of the healing of trophic ulcer after this treatment. This is a new procedure and, in selected cases, should probably be of great value.

A TECHNIC FOR LEG AMPUTATION.

Orr, Thomas G., (*Annals of Surgery*, November, 1921) presents a very rational and seemingly more adequate than usual method of amputation of the lower extremity.

He makes a long anterior and a short posterior flap in order that the scar may be placed in a posterior position both to free it from possible attachment to the bone or from pressure by the artificial limb. The deep fascia is dissected from the posterior flap in such a way that it may later be drawn up over the end of the muscles and stump in order to give a better bearing surface. The muscles are gathered over the ends of the bone with a purse-strong suture, the edge of the tibia is beveled off anteriorly so that there shall be no sharp projecting edge. The nerves are carefully freed and injected with absolute alcohol and are cut short. The anterior flap of fascia is then tacked down over the posterior flap, making an adequate buffer. A small drain is inserted laterally.

The method is well illustrated by excellent drawings.

CHRONIC DUODENAL OBSTRUCTION WITH DUODENO-JEJUNOSTOMY AS A METHOD OF TREATMENT.

Kellogg, E. L., and Kellogg, W. A. (*Annals of Surgery*, May, 1921).

Drs. Kellogg and Kellogg write as follows:

1. Chronic duodenal obstruction occurs more commonly than is realized and can often be diagnosed from the history and physical signs.
2. The most interesting articles dealing with this condition are by Robinson (1900), Conner (1906), Bloodgood (1907), and Codman (1908).
3. Experimentally, it has been shown that animals with an isolated duodenal loop die of a chemical rather than bacterial poisoning.
4. The obstruction may involve the first or second portions of the duodenum only, due to ulcer, or gastropnoia or adhesions; or the entire duodenum, most frequently caused by compression between the vertebral column behind and the superior mesenteric artery in front, especially when there is traction in the direction of the pelvis from the drag of a distended and ptosed caecum and colon.
5. The physical signs of obstruction in the first portion are those of pyloric obstruction. When the second and third portions are involved it can often be made out by percussion and succussion.

6. X-ray frequently fails to show duodenal obstruction, but may be rendered more effective if a special technic is used.

7. The symptoms are those of epigastric discomfort and toxic manifestations. With a competent pylorus, cramp-like pains predominate, when incompetent, regurgitation of bile is frequent. "Bilious attacks" are probably due to duodenal obstruction.

8. The symptoms are often suggestive of ulcer, gall-bladder, or appendicular trouble, and in operating for these conditions with negative findings the duodenum should be carefully examined.

9. Medical treatment, consisting of abdominal support, nutritious diet and anti-constipation measures, is beneficial in the majority of cases.

10. Surgical treatment in obstruction of the first and second portions consists of freeing of adhesions, gastropexy or duodeno-duodenostomy. In the third portion the procedure of choice is duodeno-jejunostomy.

11. Duodeno-jejunostomy is indicated in (a) vicious circle after gastro-enterostomy, (b) accompanying gastroenterostomy when the duodenum is obstructed, (c) in obstruction of the third portion not responding to medical treatment.

12. The total number of duodeno-jejunostomies reported are fifty-eight. There has been no mortality. In the author's series, thirty-six were completely relieved of very troublesome symptoms, four were markedly improved, and only one unimproved.

13. Duodeno-jejunostomy will save from invalidism a group of patients not amenable to other treatment and should be recognized as a definite surgical procedure.

Book Reviews.

The Early Diagnosis of the Acute Abdomen.

By ZACHARY COPE, B.A., M.D., M.S. Lond., F.R.C.S. Eng.; Surgeon to Out-Patients, St. Mary's Hospital, Paddington; Surgeon to the Bolingbroke Hospital, Wandsworth Common; Late Hunterian Professor, Royal College of Surgeons. London: Henry Frowde and Hodder & Stoughton.

Surgeons who have had a wide experience in the group of cases known generally as "the acute abdomen," will agree that in this condition correct early diagnosis is exceptional. There are still, however, many who do not appreciate to the full the significance of the earlier and less obvious symptoms of acute abdominal disease, and who regard an increased frequency of the pulse and rigidity of the overlying abdominal muscles as necessary accompaniments of the early stage of appendicitis; or find it hard to believe that a patient with a non-distended abdomen and normal pulse and tem-

perature, can be the victim of a perforated gastric ulcer.

In this compact and well printed book few references are inserted, and no bibliography appended; for while the writer readily acknowledges the great debt which he owes to the teaching of such leaders as Murphy, Moynihan, Rutheford Morison, Maylard and many others, it has been his aim to put down nothing which has not been frequently confirmed and demonstrated in his own experience.

At the same time, the writer has introduced many diagnostic points which he believes have either never previously been recorded, or to which insufficient attention is usually paid.

Treatment is not discussed apart from the general question of operative interference. With the exception of the colics, some abdominal injuries and certain tropical conditions which are discussed in their proper place, *operation by a competent surgeon at the earliest possible moment is the treatment which gives the best results in all the acute abdominal diseases described in the text.*

CONTENTS.

Chapter I—The Principles of Diagnosis in Acute Abdominal Disease.

Chapter II—Method of Diagnosis: (1) The History.

Chapter III—Method of Diagnosis: (2) The Examination of the Patient.

Chapter IV—Appendicitis.

Chapter V—The Differential Diagnosis of Appendicitis.

Chapter VI—Perforation of a Gastric or Duodenal Ulcer, Acute Pancreatitis.

Chapter VII—Acute Intestinal Obstruction.

Chapter VIII—Intussusception.

Chapter IX—Cancer of the Large Bowel—Volvulus.

Chapter X—The Early Diagnosis of Strangulated and Obstructed Herniae.

Chapter XI—Acute Abdominal Symptoms in Pregnancy and the Puerperium.

Chapter XII—Ectopic Gestation.

Chapter XIII—Cholecystitis and other Causes of Acute Pain in the Right Upper Quadrant of the Abdomen.

Chapter XIV—The Colics.

Chapter XV—The Early Diagnosis of Abdominal Injuries.

Chapter XVI—The Acute Abdomen in the Tropics.

Chapter XVII—Acute Abdominal Disease, with Genito-Urinary Symptoms.

Chapter XVIII—Spreading and General Peritonitis, Pneumococcal Peritonitis.

Chapter XIX—Diseases Which May Simulate the Acute Abdomen Index.

The reviewer recommends this little volume without reservation; in substance, style, paper, printing and illustrations, the book deserves nothing but praise. It is particularly recommended to the general practitioner.

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PNEUMONIA.

As we enter the season of increased prevalence of pneumonia, it is well to recall certain advances of practical importance in prevention and treatment. While pneumonia as a problem cannot yet be regarded as near solution as diphtheria, yet notable progress has been made and the application of knowledge already gained may be expected to diminish the morbidity and mortality of the disease which still heads the list of acute disturbances most widespread and fatal to mankind.

In the winter period of increased frequency of acute respiratory infections, it is especially important to avoid post-operative pneumonia arising in consequence of the use of general anesthetics on persons who have or are recovering from "colds," tonsillitis, laryngitis, or bronchitis. In the presence of such infections and a question of operative interference it is best, when possible, to postpone operation until the acute respiratory infection has wholly subsided. If operation is unavoidable, local is safer than general anesthesia. If general anesthesia must be used, gas oxygen or chloroform are to be preferred to ether.

Within the past ten years important advances have been made in a better understanding of the distribution and mode of transmission of the

pneumococcus. This organism has long been recognized as a common inhabitant of the normal mouth and a principal cause of all types of pneumonia. Its wide distribution among healthy persons has made it seem futile to apply the usual precautions against contagion, and for the most part such precautions have not been applied. It is now known, however, that all pneumococci are not alike in their disease-producing power. Types I and II are rarely found in normal persons, are present in a small proportion of those in intimate contact with pneumonia and are the most common cause of the more severe types of the disease. This limited distribution of Types I and II, which together cause about 60 per cent. of all cases of lobar pneumonia, offers a favorable prospect of limiting its spread by proper precautions. Types III and IV are harbored in the normal mouth and account for the remaining 40 per cent. of cases of lobar pneumonia. The indications for the control of pneumonia due to these types are less clear, but it is to be appreciated that the passage of an organism through a susceptible host increases its virulence and thus transfer of pneumococci from a patient with pneumonia favors the development of the disease. Simple methods already well understood should be instituted for the prevention of infection of those about patients with pneumonia, by isolation, and the avoidance of contact, droplet, and dust infection. Absence of sunlight and conditions of overcrowding are favorable for persistence and wider distribution of virulent pneumococci and should be avoided. Education of the public regarding the mode of transmission of organisms giving rise to contact, droplet, and dust infection is desirable. By such means a diminution of pneumonia may be expected, but methods of prevention must go further than this and gain control of those diseases which predispose to pneumonia, usually of the bronchopneumonic type, such as measles, whooping-cough, and influenza. For more successful prevention of these diseases, however, it is essential that the causes be discovered and the mode of transmission be better understood. Diphtheria, another predisposing cause of bronchopneumonia, is already preventable by application of the Schick test and the immunization of the susceptibles. The pneumonia problem should also be attacked by the further development of preventive inoculation. The work of Wright, Lister, Cecil and Vaughan, and Cecil and Blake, offers promise in this direction for man, and Cecil and Blake have recently carried the investigation a step further in monkeys, but prevention by this means is still in the experimental stage and preventive inoculation is as yet unsuitable for general adoption.

Animal experiments have shown that the repeated inoculation of animals with fixed types of pneumococci leads to the development of an immunity. The serum of such animals has specific protective and curative action against the

homologous organism. By the intravenous injection of serum obtained from horses immunized against Type I pneumococcus, favorable results have been obtained in the treatment of Type I pneumococcus pneumonia in man. Of 181 collected cases of Type I pneumococcus pneumonia without serum treatment, observed by Cole, Mathers, Fussell and Famulener, Hartman and Lacy, Clough and Richardson, 52 died, a mortality of 28 per cent. In contrast to this, is a series of 495 serum treated cases of Type I pneumococcus pneumonia, collected by Cole, including 195 treated at the Hospital of the Rockefeller Institute, with 52 deaths, a mortality of 10.5 per cent. While certain desirable details regarding the two groups are lacking and the controls are antecedent, not contemporaneous, cases, yet the number in the two series is large enough in considerable degree to balance possible errors.

Further evidence in favor of serum treatment is presented by Cecil and Blake (*J. Exp. Med.*, July 1, 1921) in the recovery of five monkeys with experimental pneumococcus Type I pneumonia, while the control monkeys all died. The serum treatment of other than pneumococcus Type I pneumonia has not proved effective, and it is undesirable to give Type I serum to all patients with pneumonia, irrespective of the type.

As in any specific serum therapy, the most favorable results are obtained by the early administration of serum. It is therefore of the greatest importance that the diagnosis of the type of pneumococcus infection be made as soon after the onset of the disease as possible. A specimen of sputum, obtained from the deeper parts of the respiratory tract, collected in a wide-mouthed, clean, and preferably sterile bottle, should be sent at once to the laboratory. As the determination of type depends on the growth of pneumococci in the abdominal cavity of a mouse, no antiseptic should be added to the sputum. The State Department of Health determines the type of pneumococci and furnishes the Type I antipneumococcus serum.

Certain precautions should be observed in the administration of alien serum to man, and they are especially important when large amounts of horse serum are given intravenously as for pneumococcus Type I pneumonia. Inquiry should be made regarding a history of asthma, hay-fever, or previous injection of serum. An affirmative reply places the patient in a group likely to be sensitive to serum. The initial dose of serum should not be given without first performing an intracutaneous test for sensitiveness and giving a desensitizing dose of horse serum. Serum treatment should not be used without first becoming familiar with the reactions which may follow and the methods of avoiding them.

THE ADDITION TO THE CHILDREN'S HOSPITAL, LONGWOOD AVENUE.

IN keeping with the modern conception of a hospital, the addition to the Children's Hospital stands as an example of the trend of the times. This institution, now in its fifty-third year, outgrew the former plant, and since 1913 has been expanding in its present location between Longwood Avenue and Van Dyke Street.

The demands for the care of children in a hospital especially equipped for this class of patients was met with enthusiastic response from the medical profession early in the history of specialization, and the foremost men in this community interested in pediatrics, orthopedic surgery and the general surgical problems of childhood, naturally grouped themselves together with the purpose of providing the best medical and surgical service. Under the guidance of these men, this hospital became more than a hotel for sick and crippled children, for the ambitions of the staff, together with benevolent contributors, have made it the field where investigation and adoption of all coordinate activities have wrought relief from suffering, so far as scientific medicine can influence the effects of disease. In addition to the benefits extended to individual patients, medical education has been aided and research stimulated by the men working within its walls.

Originally, hospitals were usually created for the purpose of caring for the indigent sick, and after it had been demonstrated that the study of disease and relief of suffering could be more efficiently prosecuted and applied in hospitals, people able to pay commensurate fees came more and more generally to those places where safety was greater and results more satisfactory than was usual in homes. How to combine hospital treatment for the indigent and paying classes has been a perplexing question, but this problem has been solved in many hospitals by the creation of wards for those able to pay reasonable charges. The income thus obtained is helpful in meeting the other expenses of maintenance and is a graceful tribute to an institution by those who can thus show their appreciation and desire to help the less fortunate.

Another feature applies to the staff, for the obligation imposed on the doctor today requires devotion to study, in addition to the performance of daily routine, and the conservation of energy necessitates arrangement of work so that time may not be wasted and fatigue may be avoided. A practice which requires attendance at hospitals and travel in seeing scattered patients should be avoided as far as possible, and therefore the segregation of patients is advantageous, enhances efficiency of the doctor and comfort of those under his care. The patient profits through the better quality of nursing service directly under the control and supervision of the attending physician.

With these ends in view, the Children's Hospital has taken the wing, formerly used as the nurses' home, and converted it into a model private hospital. In order to provide adequate quarters for the nurses, the Hotel Harvard has been acquired and made suitable for a home. The expense of remodeling the hospital wing amounts to about one hundred thousand dollars and provides ample accommodation for about forty-five patients. Certain suites are so arranged that mothers may live with the children. Four floors are given to the hospital and there are three porches which may be used as sun parlors in cold weather and open spaces in summer. The roof will also be prepared for accommodating convalescents. At the rear is a space for a flower garden.

For administrative functions every convenience has been provided. The kitchen, for example, is under the supervision of a competent executive, so that the dietary needs of patients and parents will be fully met.

The rooms are artistically decorated, with walls and hangings tinted in neutral and pleasing colors, and the furniture is in keeping with refined tastes with the idea of a home atmosphere and omission of the appearance of the usual hospital surroundings.

The operating rooms are on the upper floor and are of modern design and equipment. Accommodations for the surgeons are ample. The standards adopted by the American College of Surgeons are enforced. Special reporters are furnished for taking operating room and ward notes.

Patients of thirteen years and under are admitted and in special cases a limited number up to sixteen years. A special room is provided for the isolation of cases under observation for the possibility of the existence of a communicable disease, and no patients are permitted to mingle with others until ten days have elapsed from date of entrance.

By this extension the usefulness of a hospital, which admitted 4,682 patients last year and treated 11,396 in the out-patient department, is greatly augmented, and makes a notable addition to Boston's facilities for treating children's disabilities.

All who are interested in the economic aspect of curing disease should realize that the promotion of the health of a child may give to society valuable and useful lives for many years. The Children's Hospital is entitled to the endorsement of the medical profession and material assistance by the laity.

NEWS ITEMS.

DR. S. ADOLPHUS KOPF recently completed the manuscript for "The History of the Tuberculosis Movement in the United States," and this publication will be issued about April 1st. The January issue of the *Tuberculosis Bulletin* will

be devoted to a symposium on tuberculosis in industry. Among those who will contribute to this number from their respective angles and interests, are the following: Dr. Louis I. Harris, Dr. George R. Price, Dr. Galdston, Mr. Hochhauser and Mr. Hamilton of the N. T. A. Staff.

A MEETING of the Harvard Medical Society was held in the Peter Bent Brigham Hospital Amphitheatre Tuesday evening, January 24th. Program: "Physiological Principles Governing Ventilation when the Air is Contaminated with Carbon Monoxid." Speaker, Dr. Yandell Henderson, Yale University.

LAWRENCE REYNOLDS, Sec.

DR. RICHARD P. STRONG AND GORGAS MEMORIAL.—It has been announced that Dr. Richard P. Strong has accepted the position of Scientific Director of the Gorgas Memorial Institute at Panama. This does not mean that Dr. Strong intends to leave Harvard University. He will continue to direct his work here and will organize the Scientific Department of the Gorgas Memorial.

PROFESSOR HENRY CHRISTIAN and Professor W. B. Carmin will attend the meetings of the Pacific Northwest Medical Association at Spokane, next July.

DURING the week ending January 21, 1922, the number of deaths reported was 257 against 219 last year, with a rate of 17.51. There were 28 deaths under one year of age against 27 last year.

The number of cases of principal reportable diseases were: Diphtheria, 68; scarlet fever, 61; measles, 65; whooping cough, 13; tuberculosis, 38.

Included in the above were the following cases of non-residents: Diphtheria, 6; scarlet fever, 13; tuberculosis, 2.

Total deaths from these diseases were: Diphtheria, 5; scarlet fever, 2; whooping cough, 1; tuberculosis, 12.

Included in the above were the following cases of non-residents: Diphtheria, 1; scarlet fever, 2; tuberculosis, 1.

IN New York, most of the cases of bone and joint tuberculosis applying for relief at the Lorenz clinic were among those of foreign extraction or residents of other cities—in other words, among those who had not applied for orthopedic treatment in the city.

BOVINE tuberculosis is specially prevalent in certain parts of Scotland, and in those areas there is an undue proportion of bone, joint and gland cases, according to statements made by Dr. Stiles of Edinburgh.

DURING the week ending January 14, 1922, the number of deaths reported was 222 against 198 last year, with a rate of 15.15. There were 20 deaths under one year of age against 26 last year.

The number of cases of principal reportable diseases were: Diphtheria, 65; scarlet fever, 52; measles, 63; whooping cough, 12; tuberculosis, 76.

Included in the above were the following cases of non-residents: Diphtheria, 6; scarlet fever, 10; tuberculosis, 43.

Total deaths from these diseases were: Diphtheria, 6; scarlet fever, 1; measles, 1; tuberculosis, 8.

Included in the above were the following cases of non-residents: Diphtheria, 2; tuberculosis, 1.

HAMPDEN DISTRICT MEDICAL SOCIETY.—The regular winter meeting of the Society was held at the Springfield Academy of Medicine, 137½ State Street, Springfield, on Tuesday, January 24, at 4 p.m. Papers for the afternoon: "Gas Oxygen as a General Anaesthetic," James A. Seaman; "Some Figures on Cesarean Section," John M. Birnie; "Myositis Ossificans Traumatica," Dudley Carleton; Discussion by members. Mr. George Crosbie of Boston was present and explained the new insurance. Luncheon was served at expense of the Society.

WORCESTER DISTRICT MEDICAL SOCIETY.—The regular meeting of the Staff of the Worcester City Hospital was held Friday, January 20, 1922, at 8.30 p.m. Dr. Charles T. Estabrook described otitis meningitis and reported several cases. Dr. Gordon Berry exhibited his latest instruments for removal of foreign bodies in the esophagus, and showed a large number of such bodies which he had removed. Dr. Wm. F. Holzer described the diseases of the eye common in childhood. Dr. O. Draper Phelps reported a case of calculus outside of the urinary tract. Operation revealed that it was a calcified gland in the mesentery, which was removed. Dr. Walter B. Bieberback reported a case of calculus in the ureter which was missed by the x-ray. He stated that about 20 per cent. of urinary calculi were missed by the x-ray. Dr. Philip H. Cook discussed radium and its place in minor troubles.

THE Rockefeller Institute for Medical Research, on January 20, celebrated the 20th anniversary of its foundation with a reception, at which brief speeches were made by Mr. John D. Rockefeller, Jr., of the Board of Trustees, and Dr. William H. Welch, of the Board of Scientific Directors.

MASSACHUSETTS GENERAL HOSPITAL.—A clinical meeting of the Out-Patient Staff was held in the lower out-patient amphitheatre Wednesday, Jan. 25, at 12, noon. Program: "Present

Conception of Colon Pyelitis as Regards Treatment," Dr. E. G. Crabtree; "Management of Cancer of the Bladder," Dr. G. G. Smith; "Result of Study of the Question of Renal Calculi," Lantern Slides, Dr. J. D. Barney.

THE membership of the Massachusetts Medical Society amounts to three thousand nine hundred and thirty-three. The accessions for 1921 amount to two hundred and thirty.

MEDICAL NOTE.

A SERIES of institutes has just been completed under the auspices of Nutrition Clinics for Delicate Children. They have been held in Indianapolis, San Francisco and Los Angeles, in each case at the invitation of the medical societies, the Board of Education and the child-helping organizations, especially those concerned with the prevention of tuberculosis. In Indianapolis, there were 45 in regular attendance; in San Francisco, about 80; and in Los Angeles, 179. In each city special lectures were given by Dr. Wm. R. P. Emerson, before the county medical societies and other organizations. Los Angeles arranged for a special meeting of orthopedists, specialists in children's diseases and in tuberculosis. Addresses were given on nutrition work before large audiences in Vassar College, Leland Stanford, Jr., University, and the Universities of California and Southern California. A conference held at Honolulu has led the Social Service Bureau of the Hawaiian Islands to secure funds for an institute to be held there some time this spring.

Obituaries.

FREDERICK WADSWORTH HALSEY, M.D.

DR. FREDERICK W. HALSEY, for many years a teacher of diseases of the rectum in Boston University Medical School, died at his home in Boston, January 20, 1922, at the age of seventy-two, of angina pectoris.

He was a native of Plattsburg, N. Y., where he was born July 3, 1849; a graduate of George Washington University Medical School in 1871. Beginning to lecture on his specialty at Boston University Medical School in 1890, he was made associate professor in 1915 and professor emeritus last year.

He is survived by his widow, who was Miss Elizabeth Chapman of Vermont, and by two daughters. At one time Dr. Halsey was vice-president of the Massachusetts Homeopathic Medical Society, and he was a fellow of the American College of Surgeons.

WILLIAM CASTEIN MASON, M.D.

DR. WILLIAM C. MASON, surgeon, of Bangor, Maine, died in that city January 19, 1922. The son of John and Caroline Rogers Mason, he was born in Bangor, September 1, 1852. He received the degree of A.B. from Harvard in 1874, and from Harvard Medical School in 1878, serving as house officer at the Massachusetts General Hospital. He joined the Massachusetts Medical Society in 1877 and maintained membership for seven years, though settling in Bangor. There he was city physician from 1879 to 1881 and acting assistant surgeon in the Marine Hospital. From 1892 to 1907, he was visiting surgeon to the Eastern Maine General Hospital, which he had helped to organize, after the latter date being consulting surgeon, as he was also for many years, to the Eastern Maine Eye and Ear Infirmary and the Home for Aged Women.

Among the memberships he held may be mentioned the Penobscot County Medical Association, Maine Medical Society, Association of Military Surgeons of the United States, Bangor Historical Society, Maine Genealogical Society, Harvard Clubs of Bangor, Maine, and Boston, and in addition, several Masonic chapters.

 Miscellany.

DOMESTIC QUARANTINE AND VENEREAL DISEASE.

"THE migration of persons suffering with venereal disease from their home state to another state without first procuring from their local health officer a permit, stating that their travel is not dangerous to public health, violates the Federal law forbidding the spread of contagious diseases and will be rigidly suppressed," says the U. S. Public Health Service.

"Last spring the Attorney General, at the request of the Service, instructed all United States attorneys to cooperate fully with it and to prosecute offenders vigorously. Since then several violators have been sentenced to reformatories, where their disease-spreading activities have been stopped and they, themselves, are receiving proper medical treatment.

"The law and the regulations based on it are not so widely known as they should be; and the objects sought in their enforcement are not everywhere clearly understood. The law seeks to control the spread of disease, but not necessarily to prevent the travel of venereally diseased persons. Such travel, if undertaken under proper precautions in search of medical help, will be encouraged by the Service. The

law, however, seeks to close every channel through which venereal disease may be spread; and to do this it has been found necessary to put a stop to the movements of those who seek to migrate from one state to another in order more safely to carry on the business of spreading disease.

"When such persons and their associates learn that travel from one state to another while venereally diseased, leads to arrest and severe punishment, they will have an added incentive for submitting to voluntary treatment; and the day will be hastened when every infected person will at once place himself, or herself, under the care of a skilled physician of his, or her, own selection.

"At present, it is probable that very many persons either never receive proper treatment or that they cease treatment too early in the belief that they are cured, and thus become dangerous. Laws on the subject differ in the different states; and this fact leads to migration from those whose laws are rigid to those whose laws are less so.

"No attempt, either by the U. S. Government or by state governments to police the state borders seems practicable. The laws of practically all states, however, require physicians to report all venereal cases that come to their attention; and a judicial or police investigation of the history of any apparent new-comer who chances to be arrested will early disclose most of the new arrivals in the state. These may then be proceeded against under United States law.

"Proceedings," adds the U. S. Public Health Service, "are based on the Interstate Quarantine Regulations, whose making by the Secretary of the Treasury was authorized by Congress February 15, 1893 (27 Stat. ch. 114, p. 449), amended March 3, 1901 (31 Stat., ch. 836, p. 1086). Objections on the ground that the regulations are insufficient or defective, or that Congress may not delegate its legislative authority, are without merit. The Secretary's act in making the regulations is administrative, and is authorized by the act of February 15, 1893. The penalty for violation is fixed by Congress, is legal, and has been sustained in United States courts. Details of the above are given in Reprint 693 of the U. S. Public Health Service, just issued."

Permits for travel obtained from the local health officer must state that the travel, in the opinion of the officer, is not dangerous to the public health. The traveler must state where he intends to reside; and he must agree, in writing, to report to the proper health officer there within one week after arrival, and to continue treatment under a reputable physician until the health officer certifies that he is no longer infectious. The health officer who issues the permit must promptly notify the new health officer, who must take appropriate action.

THE NEWER AMERICAN MEDICINAL CHEMICALS.

ON Friday, January 6th, Dr. Alfred S. Burdick of Chicago, delivered an address before the Chicago Branch of the American Pharmaceutical Association, on the "Newer Medicinal Chemicals." The rapid growth of American chemistry through coöperation of all research agencies in this country, was emphasized by the speaker.

Concrete examples of American achievements in synthetic chemistry were recited, and a plea made for the support of the medical and pharmaceutical professions to preclude the possibility of our again becoming dependent upon foreign sources for chemical supplies. The history of arsphenamine, barbital, cinchophen, neocinchophen, chlorazene, procaine, the benzyl esters and other synthetic medicinal chemicals was outlined. Announcement was also made of a number of new chemical bodies recently developed, and others on which research work was now being done by the Rockefeller Foundation, various universities, the American Medical Association and the Abbott Laboratories.

In conclusion, Dr. Burdick urged both physicians and pharmacists to prescribe and dispense medicinal chemicals by the newer American names, rather than to perpetuate the prewar dominance of foreign synthetics. This position was supported by the Council on Pharmacy and Chemistry of the American Medical Association, in whose laboratories American medicinal products have been analyzed and found to be equal, and in some cases superior, to foreign-made products.

A TRIBUTE TO THE SURGEON-IN-CHIEF OF THE HOSPITAL FOR RUPTURED AND CRIPPLED—DR. V. P. GIBNEY.

ON November 21, 1921, a dinner was given to Dr. Virgil P. Gibney, the present surgeon-in-chief of the Hospital for Ruptured and Crippled of New York City. This took the form of a jubilee, commemorating the fiftieth year of his connection with the hospital. It was given in the East Ballroom of the Hotel Commodore, corner of Lexington Avenue and 42nd Street, a particularly appropriate location, as the old Hospital for Ruptured and Crippled stood exactly on this site from 1870 to 1912, when the new building which it now occupies on 42nd Street, between First and Second Avenues, was completed.

Fifty years ago (1871) Dr. Gibney came to the Hospital for Ruptured and Crippled as interne, under its founder, Dr. James Knight. The institution had been in existence since 1863, at which time it occupied the private residence of Dr. Knight at 97 Second Avenue,

with accommodations for twenty-eight children. When Dr. Gibney began his internship, the new structure, with accommodations for two hundred children, was located at 42nd Street and Lexington Avenue, and had been occupied for about a year. In 1898, an additional building at 43rd Street and Lexington Avenue, communicating with the old hospital on 42nd Street, was completed. It is interesting to note that the hospital was so far up-town that it was regarded as a country hospital. The location of the hospital at the present time—two blocks east of this older site—is virtually in the heart of the city.

The growth of the Hospital for Ruptured and Crippled has been constant, in the variety of cases treated, as well as in their number.

During the first year that Dr. Gibney was associated with the hospital, the number of patients treated was 2,721, consisting of varicose veins, bowleg, knock-knee, club-foot, paralysis, curvature of the spine, spinal disease, hip disease, rickets, "white swelling," rheumatic contraction, hernia, etc. At this stage in the development of the institution, no surgical operations of any magnitude were performed, but in 1887, when Dr. V. P. Gibney, who had been resident assistant for 13 years, was appointed surgeon-in-chief, this phase of orthopedic treatment began to develop. Dr. William T. Bull was placed in charge of the hernia department at this time, and at his suggestion, children with hernia, who were not cured by trusses, were admitted to the wards for operation.

With the increased amount of work it has been necessary to divide the service of the hospital into four divisions: two orthopedic, with Drs. Royal Whitman and Henry Ling Taylor in charge; and two hernia, with Drs. William B. Coley and John B. Walker in charge. Dr. Virgil P. Gibney is the Surgeon-in-chief.

The present building is a modern six-story, brick structure, fully equipped with x-ray and pathological laboratories, brace-shop and sewing room employing nineteen people, plaster room for preparation of plaster of Paris bandages, Zander room, hydrotherapy department, laundry, refrigerating plant, etc. Most of the fifth floor is devoted to schoolrooms, including a large assembly hall, attractively adorned with kindergarten studies, etc., containing a piano and a moving-picture outfit, where convalescent children receive instruction from the municipal teachers of the City of New York, and where entertainments are given.

There are nine wards, with accommodations for 250 patients, including two wards for men and one for women. There are two operating rooms with adequate facilities for sterilization of supplies, adjoining anesthetizing rooms, dressing rooms, etc. During the year ending September 30, 1920, there were 1,256 orthopedic operations and 1,094 hernia operations performed, and a total of 2,268 in-patients

treated. The out-patient department, with its separate divisions for orthopedic cases, hernia, neurological, dental, nose and throat, corrective exercise classes, etc., is located on the ground floor with a large waiting room and light and airy examining room for children, with 16 separate booths. On this floor also are located the examining rooms for men and women, the plaster rooms, small operating room and rooms devoted to physiotherapy. In 1920 the number of new cases examined and treated in the out-patient department was 12,889. In the reports of the hospital, a very striking fact in comparing the recent reports with the old, is the increase in the number of cases of infantile paralysis treated and the marked diminution in the number of cases of bone and joint tuberculosis.

At the jubilee dinner, the development of the hospital, under Dr. Gibney, was briefly sketched. The attendance at this dinner of over 350, from many parts of the continent, representing the far West as well as the extreme South and our northern neighbor, Canada, attested much better than any mere description, the esteem in which the Chief is held by those who received their early training under his guidance, and who considered it a privilege to journey to New York City to congratulate him and wish him many more years of his useful and kindly service to the institution. Every man fortunate enough to have had a service under Dr. Gibney, carried away with him memories of kindness which time cannot dim. His unflinching zeal and untiring efforts to relieve the patient and to advance the science of orthopedic surgery have been an inspiration to his interested followers.

ISADOR ZADEK, M.D.
EARL E. VANDERWERKER, M.D.

EXCERPTS FROM STATEMENTS MADE BY THE SURGEON-GENERAL OF THE UNITED STATES.

The dependence of national prosperity upon national health has ceased to be submerged in the public consciousness, and the necessity for adequate health protection is now a generally accepted fact.

The death rate from tuberculosis for the United States in 1910 was 160.3 and for 1920, 114.2. Again in 1910 the general typhoid fever death rate was 23.5 per hundred thousand population, in 1920, 7.8. It is safe to say that if in 1910 the statement had been made that in ten years' time the typhoid fever death rate would be only one-third of the figures at that time, the sanitarians generally would have been profoundly sceptical of any such prediction.

There are no considerable figures available from which an accurate statement can be made

regarding the infant mortality rate for the United States in 1910, but a conservative estimate would make the rate approximately 124 per thousand births. In 1920 the infant mortality rate in the birth registration area of the United States was 86 per thousand births, a clear gain of approximately 38 points in the last ten years. As a means to further reduce this rate may be noted the passage of the Sheppard-Towner Maternity bill by virtue of which Federal funds are made available to the States. These funds will undoubtedly initiate much work on the part of the States and local communities to preserve maternal and infant life.

Again, in 1910 the scarlet fever death rate was 11.6 per hundred thousand population, and in 1920 it had fallen to 4.6. This illustrates the efficacy of general measures for the control of communicable diseases which play such an important part in the organization and activities of our various state and local departments of health.

The mortality from diphtheria shows the advance of preventive medicine in the control of this dread disease of childhood. The death rate from diphtheria in 1910 was 21.4 per hundred thousand population, and in 1920 it had sunk to 15.3.

In 1910 the death rate from diarrhea and enteritis in children under two years of age was 100.8; in 1920 this had dropped to 44.0. Thus has the toll taken by this scourge of infant life been reduced by more than half.

In 1910 the general death rate from pneumonia, all forms, was 147.7 per hundred thousand population, and in 1920 this death rate was 137.3. We have, therefore, made but relatively little advance in the problem of pneumonia control. The death rate from acute nephritis and Bright's disease was 99 in 1910, and had declined but to 89.4 in 1920. The death rate from cerebral hemorrhage, or apoplexy, in 1910 was 73.7 per hundred thousand population and rose to 80.9 in 1920. The case is similar as regards cancer. The death rate from this disease in 1910 was 76.2; in 1920, 83.4, an increase of over seven points per hundred thousand population. Again, the death rate from organic diseases of the heart was 141.5 in 1910 and the figures of 1920 show the rate to be 141.9, showing that no reduction from this great cause of death has taken place.

A preliminary stocktaking of the kind we have just outlined serves to show us where our health problems lie. That our measures against some of the communicable diseases have been fraught with so much success encourages us to undertake the difficult problems of the control of such diseases as organic heart diseases, cancer, pneumonia, kidney diseases, and the like.

Apart from the control of these diseases, one of the crying needs of the country is better organization of health work in the rural communities. A survey made by the Public Health Ser-

vice two years ago showed that only 3 per cent. of our rural districts had adequate local health organizations. It is a pleasure to announce that this number has increased during the past two years from 3 to 6 per cent. This only emphasizes the inadequacy of health service in our rural communities.

RÉSUMÉ OF COMMUNICABLE DISEASES. DECEMBER, 1921.

General Prevalence.

THERE were 5,940 cases of communicable diseases reported for this month. This represents a report of moderate size and was exceeded 2,000 cases by the report of December, 1920.

Anterior Poliomyelitis was reported in 10 instances, which was five less than the previous month.

Chicken-pox.—There were 900 cases of this disease reported for the month. For this season of the year this is not a large monthly total.

Diphtheria.—There were 1,088 cases reported for the month; total for last month, 1,185 cases. This, as last month, represents a large report and is the result of widespread incidence throughout the state.

Dog-bite requiring anti-rabic treatment.—There were 19 cases of this condition reported for the month. This is a large monthly total.

Gonorrhea and Syphilis.—Gonorrhea fell off from 460 to 372 for this month. Syphilis was reported in about the usual number, there being a total of 217 cases.

Influenza.—There were 46 cases of influenza reported during December.

Measles increased from 678 for November to 835 for this month. This is about the usual incidence of this disease at this season.

Lobar Pneumonia was reported 382 times. This is about the same number as reported the previous month.

Scarlet Fever increased from 661 for November to 740 for December. This is the usual history at this time.

Tuberculosis, Pulmonary.—There were 524 cases reported for the month, which is about the usual number.

Tuberculosis, other forms, were reported in 74 instances.

Typhoid Fever was reported 52 times.

Whooping Cough.—There were 249 cases reported for the month. This is the second month that the reported incidence has been relatively small.

RARE DISEASES.

Anterior Poliomyelitis was reported from Arlington, 1; Boston, 3; Haverhill, 1; Lawrence, 1; Melrose, 1; Norton, 1; Palmer, 1; Springfield, 1. Total, 10.

Dog-bite requiring anti-rabic treatment was reported from Boston, 1; Charlton, 1; Chelmsford, 4; Holyoke, 1; Lexington, 2; Lowell, 1; Lynn, 5; Newton, 1; Pittsfield, 1; Woburn, 1. Total, 18.

Encephalitis Lethargica was reported from Boston, 1; Chicopee, 1; Newton, 1. Total, 3.

Epidemic Cerebro-spinal Meningitis was reported from Boston, 1; Concord, 1; Everett, 2; Groton, 1; Holyoke, 1; Lynn, 1; Peabody, 1; Springfield, 1; Woburn, 1. Total, 10.

Malaria was reported from Boston, 2.

Septic Sore Throat was reported from Arlington, 1; Boston, 4; Braintree, 1; Fairhaven, 1; Fall River, 1; Lynn, 3; Leominster, 1; Methuen, 4; Middleboro, 1; Newburyport, 3; Stoughton, 2; New Bedford, 3. Total, 25.

Trachoma was reported from Boston, 2; Lynn, 1; Northbridge, 1; Springfield, 1. Total, 5.

Typhus Fever was reported from Boston, 1.

TUBERCULOSIS SCHOOLS FOR U. S. PUBLIC HEALTH SERVICE PHYSICIANS.

THE tuberculosis schools for medical officers in soldier hospitals and examining stations which were established some 18 months ago by the U. S. Public Health Service and were recently taken over by the Veterans' Bureau, have trained several hundred service physicians, four-fifths of whom have qualified in making special examinations of the chest and in reporting thereon with accuracy satisfactory to the somewhat exacting requirements of the Rating Board of the Veterans' Bureau. This has lessened the expenses for travel and the inconvenience and hazard to tuberculous veterans in going long distances to chest specialists, and has more than balanced the cost of the schooling.

These schools were established in the spring of 1920 in various parts of the United States. Courses of instruction were arranged and the students were chosen from among the medical officers and specialists in the service of the United States Public Health Service.

The course embraced instruction in topography, inspection, palpation, percussion, and auscultation, demonstrations of the normal chest, chest pathology, and finally a study of advanced cases in hospitals. The classes were divided into small sections for individual instruction under specialists, who guided each student through the steps of diagnosis, and taught him to visualize the conditions accountable for the physical findings.

A lecture and clinic on the heart, and a short course in x-ray and laboratory work, were also given, and cinema diagnostic films were exhibited. The latest course was held at Chicago during the week of December 5-11.

THE LEGISLATURE.

THE COMMONWEALTH OF MASSACHUSETTS.

REGISTRATION OF X-RAY TECHNICIANS.

A bill has been introduced (Senate 115), on petition of H. A. Moses:

To provide for the Registration of X-Ray Technicians.

It directs the board of registration in medicine to hold examinations for the registration of X-ray technicians. An applicant must be at least twenty-one, of good moral character and possessing such educational qualifications as persons who have completed one year in a public high school, and who have had one year of actual experience in practice in an X-ray laboratory or school in which the course of study consists of not less than twenty-five hours per week for a period of forty-eight weeks. Those found qualified shall be registered X-ray technicians, with the right to use the title, including the letters "R. T." as signifying registered technician, and to practice as such, and shall receive a certificate. The registration must be renewed annually. The board may, after a hearing, by vote of a majority of its members, annul the registration and cancel the certificate of any X-ray technician; and, without a hearing, may annul the registration and cancel the certificate of an X-ray technician who has been found guilty of a crime.

Examinations shall be partly in writing and partly in practical work, and shall include the principles of electricity, light, photography, physics and the action of X-rays on bodily tissues.

The board may register, without examination, any person who for a period of two years has made his principal occupation that of roentgenological technician, has devoted twenty-five hours per week as an actual assistant in roentgenological work with a licensed roentgenologist.

A registered technician shall practice his profession only as assistant to and under the direct supervision of a registered physician or dentist, and shall not use the X-ray except as directed and prescribed in each case for the treatment of disease by the supervising physician or dentist, or for the making of radiographs or X-ray pictures, and in no case shall he diagnose or profess to diagnose any disease that may be revealed thereby.

The board shall keep a record of all persons registered by it, and shall make an annual report.

A roentgenologist is defined as a graduate in medicine or dentistry who has by means of study and experience gained special skill in the use of the Roentgen ray or X-ray. An X-ray technician is defined as a person skilled in the use of the Roentgen ray or X-ray, but who does

not profess to diagnose disease from the plates taken, nor to designate methods of applying the X-ray in treatment. Penalties are provided for the violation of the act.

MIDWIFE REGISTRATION.

An Act for the registration of midwives (House 423) provides that no persons shall practice midwifery, or hold out as a midwife, unless she is registered.

The Board of Registration in Medicine shall hold at least two examinations annually.

An applicant must be twenty-one years of age or over, of good moral character, and a graduate of a reputable school for midwives, approved by the board, and which gives a course of not less than six months.

Examinations shall be written, oral or practical, as the board may determine, and shall include obstetrics, and prenatal and post-natal care. Qualified applicants shall be registered.

Registered midwives shall not be permitted to use any operative measures such as version, forceps, or any instruments except those necessary to sever the umbilical cord, or employ any drug, other than disinfectants and the salts of silver as applied to the eyes of infants.

Every registered midwife shall, before entering upon practice, submit her certificate of registration to the clerk of the town where she proposes to practice. The town clerk shall thereupon register her name and address, the date and number of the certificate, and said record shall be open to public inspection. A copy of such record shall be sent by the town clerk to the board within one week.

The board of registration is to be granted necessary assistants and the power to investigate complaints of the violation of the bill. Penalties are provided for violation of the act.

This bill has been referred to the Committee on Public Health. There are in the profession two views regarding registration. Those who believe in the policy of recognizing and educating midwives will naturally favor this bill. Those who believe in the gradual elimination of midwives by education and gradual conformation to American customs, will be opposed to any bill which recognizes midwives.

Other bills will be considered in later issues of the JOURNAL.

Various measures have been proposed which deal with the taxation of charitable institutions. Some of these measures will intimately concern hospitals.

NARCOTICS.

Senate 140, taken from the files of last year, provides the establishment of a Division of Registration and Narcotic Drug Control.

The bill reads essentially thus:

"There shall be a department of civil service and registration, which shall consist of a division of civil service and a division of registration and narcotic drug control. The commissioner of civil service and the director of registration and narcotic drug control shall act as a board in all matters affecting the department as a whole.

"The division of registration and narcotic drug control shall be under the supervision of a director to be known as the director of registration and narcotic drug control, at a salary, not exceeding four thousand dollars, appointed for two years.

"The various boards of registration and examination shall serve in the division of registration and narcotic drug control.

"Chapter one hundred and twelve of the General Laws is hereby amended by inserting under the heading, 'Narcotic Drug Control,' the three following new sections: (1) The director of the division may annually register such persons as he deems proper to engage in the business of the manufacture and sale of narcotic drugs, upon payment of the following fees,—wholesale jobbers, importers and manufacturers, five dollars; incorporated hospitals, scientific institutions and retail dealers, one dollar. (2) No person, except physicians and surgeons, pharmacists, dentists and veterinarians registered under this chapter, shall manufacture or have in his possession for purposes of sale any narcotic drugs, unless he is registered under the provisions of the preceding section. (3) The director of the division and the state police shall enforce the provisions of the two preceding sections and shall have the right to enter and inspect the place of business of any person registered under said sections.

House 600 forbids the sale or delivery of hypodermic syringes and needles except to registered physicians duly licensed to procure them.

Two bills introduced in the House on petition of William L. Roberts, Jr., stiffen the penalties for the unlawful possession or sale of narcotic drugs or hypodermic syringes or needles, to imprisonment for not less than three years in the first instance and not less than two in the other.

On petition of Samuel H. Wragg, a bill has been introduced in the House to restrict the use of habit-forming drugs. It forbids the possession by or sale to any person, not being a physician, dentist or veterinarian, pharmacist, manufacturer of surgical instruments, nurse, employee of an incorporated hospital, or a carrier engaged in transportation, of a hypodermic syringe, or hypodermic needle. It provides that a record shall be kept by the person selling such syringe, needle or instrument, which shall give the date of the sale, the name and address of the purchaser, and a description of the

instrument which record shall be open to inspection by the proper authorities.

It provides, further, that each building, place or tenement which is resorted to by habitual users of narcotic drugs for the purpose of using such drugs, or which is used for the illegal keeping or sale of the same, shall be deemed a common nuisance. Penalties of imprisonment are provided.

TREATMENT OF TUBERCULOSIS.

On petition of W. I. Hennessey, there has been introduced in the House the following Resolve providing for the appointment of a commission to investigate the feasibility of establishing a hospital for the treatment of surgical or non-pulmonary tuberculosis.

Resolved, That there be appointed by the Governor, with the advice and consent of the council, a commission consisting of seven persons, three of whom shall be registered physicians, who shall study and investigate the feasibility of establishing treatment of surgical or non-pulmonary tuberculosis. Said commission shall serve without compensation, but may be allowed for travel and necessary clerical expenses, such sums of money as the Governor and council may determine. They shall report to the next general court not later than the first Wednesday in January next, such legislation as may be deemed necessary.

TAXATION.

Several bills have been introduced, the intent of which is to call upon the State to meet, from its treasury, in whole or in part, the sum of such taxes as might now be levied by various municipalities upon educational institutions within its borders, were it not that such institutions were at present exempt from taxation.

Senate 37 provides that "if any of the income or profits of the business of the institution is . . . used for other than literary, educational, benevolent, charitable, scientific or religious purposes, its property shall not be exempt" from taxation.

House 373 provides that no insane hospital shall be exempt from taxation unless at least one-fourth of the property and one-fourth of the income is devoted to the care of free patients.

House 385 accompanies the petition of the Trustees of the Massachusetts General Hospital. It provides that no insane hospital shall be exempt from taxation unless one-fourth of all the resident patients shall be paying less than twenty-five dollars per week.

House 514 and 515 are introduced on petition of John Lowell.

One bill substitutes for certain clauses in the existing law the provision that the land owned and used by an insane hospital shall be subject to taxation.

REGULATION OF THE SALE OF CANDY.

House 497 is trying to place candy in the class with cigarettes and intoxicants. It forbids the sale of candy or other sweetmeats to any child of thirteen years of age or less without the written consent of parent or guardian.

VITAL STATISTICS.

House 143 provides for the employment of transcribers of town records of vital statistics and for the publication of such records by the Secretary of State in accordance with appropriations which may be made by the Legislature.

TUBERCULIN TEST.

House 534 provides that any person selling a cow which has reacted to a tuberculin test must inform the new owner in writing of this fact. The bill does not state that the information is to be given before the bargain is closed.

WORKING AGE FOR CHILDREN.

House 610, on petition of the American Federation of Labor, provides for raising the working age of children from fourteen to sixteen years.

COMMITMENT AND CONFINEMENT.

Three bills have been introduced, dealing with commitments to or confinements in institutions.

House 584 provides that no person shall be committed to an institution without reasonable notice, an opportunity to appear, and defend, with the request of a trial by jury. Exception is made only in the case of one being violent, and then for three days only.

House 602 is introduced on petition of the Order of Patriot Dames. It provides that it shall be unlawful to confine in an institution, any human being against his will and without his continuing consent, except as a punishment for crime. It further impresses upon every sheriff, notary, justice, court officer, and member of the Legislature, the duty of investigating any complaint in regard to any institution.

Comment upon these bills would be superfluous.

House 588, because more reasonable, may be seriously considered.

It provides that no state minor ward shall be committed to any state institution for the feeble-minded or insane unless examined by three reputable physicians appointed by the court. The bill, however, would exclude, oftentimes, those best fitted to judge in such a matter, by forbidding the employment of any physician employed in any capacity by the State or by any county or city.

The bill seems unnecessary. The latter clause appears unwise.

House 365 provides for regulating the manufacture and bottling of non-alcoholic beverages with a view to keeping them pure.

House 614, upon petition of the Massachusetts Undertakers' Association, removes the Board of Registration in Embalming from its present independent existence and places it in and causes it to hereafter serve in the Department of Public Health.

The reasons for such transfer are by no means obvious.

House 650, although applying only to the City of Malden, is of interest because it would establish a precedent. On petition of the Mayor and City Solicitor, it is proposed to abolish the board of health and the overseers of the poor, and to establish a single board of health and charities consisting of three members. The Mayor is also directed under civil service regulations to appoint an agent who shall be secretary and administrative officer of the board.

U. S. EXAMINATION FOR SPECIALIST IN CHILD HYGIENE.

BELOW will be found the specifications governing the selection of a specialist in child hygiene and for the filling of vacancies in other positions in The Children's Bureau.

Many careful students of our responsibilities and opportunities under the Sheppard-Towner bill, feel that since it has been enacted into law and may be adopted by many states, that every effort should be made to secure the greatest good possible under its operation.

We certainly need well-trained minds in the Children's Bureau, and it is quite well known that Massachusetts has many men qualified to fill positions specified in the circular.

Specialist in Child Hygiene, \$2,400-\$4,000. Receipt of applications to close February 14, 1922.

The United States Civil Service Commission announces an open competitive examination for specialist in child hygiene. A vacancy in the Children's Bureau, Department of Labor, Washington, D. C., at \$2,400 to \$4,000 a year, and vacancies in positions requiring similar qualifications, at these or higher or lower salaries, will be filled from this examination, unless it is found in the interest of the service to fill any vacancy by reinstatement, transfer, or promotion.

Range in salary.—The entrance salary within the range stated will depend upon the qualifications of the appointee as shown in the examination.

Travel.—The appointee will be allowed actual traveling expenses and a per diem in lieu of subsistence when absent from headquarters on official business.

Duties.—The duties of appointees will be to plan and conduct investigations into the causes of infant, child, and maternal mortality in selected communities, rural and urban; into the methods of their prevention; into dangerous and injurious occupations; into the health of dependent, delinquent, and defective children, and other matters relating to the

health of children. Appointees may also be required to investigate maternal and child welfare through the holding of conferences.

Subjects and weights.—Competitors will not be required to report for written examination at any place, but will be rated on the following subjects, which will have the relative weights indicated:

SUBJECTS.		Weights
1. Education		25
2. Experience		50
3. Publications or thesis (to be filed with application)		25
Total		100

Basis of ratings.—The ratings on the first two subjects will be based upon competitors' sworn statements in their applications and upon corroborative evidence.

Education and experience.—Applicants must have graduated from a medical school of recognized standing; and, in addition, have had at least three years' specialization in the hygiene and diseases of maternity and childhood, either in the practice of medicine, or in educational preventive work in connection with maternal, infant, and child mortality conducted by public or private agencies.

Writings.—Under the third subject, applicants must submit with their applications publications of which they are the author on matters pertaining to child hygiene or the prevention of maternal, infant, and child mortality, or on the health of children in industry, or on the health of dependent, delinquent and defective children, or in lieu of such publications, a thesis on one of these subjects; or both such publications and theses may be submitted.

Oral examination.—An oral test will be given at selected centers on a later date to those attaining an eligible average in the examination to determine their fitness for the position. This oral test will be given to competitors in the order of their standing and only to such number as the needs of the service require. A competitor who fails to pass the oral examination will not be eligible for appointment. Competitors will be notified of the date and place of the oral examination.

Age.—Applicants must not have reached their fiftieth birthday on the date of the examination. This age limit does not apply to persons entitled to preference because of military or naval service.

Retirement.—Classified employees who have reached the retirement age and have served fifteen years are entitled to retirement with an annuity. The retirement age for railway mail clerks is 62 years, for mechanics and post-office clerks and carriers 65 years, and for others 70 years. A deduction of 2½ per cent. is made from the monthly salary to provide for this annuity, which will be returned to persons leaving the service before retirement with 4 per cent. interest compounded annually.

Photographs.—Applicants must submit with their applications their unmounted photographs, taken within two years, with their names written thereon. Proofs or group photographs will not be accepted. Photographs will not be returned to applicants.

Residence and domicile.—Applicants will be admitted to this examination regardless of their residence and domicile; but only those who have been actually domiciled in the State or Territory in which they reside for at least one year previous to the examination and who have the county officer's certificate in the application form executed, may become eligible for permanent appointment to the appointed service in Washington, D. C.

Applications.—Applicants should at once apply for Form 2118, stating the title of the examination desired,

to the Civil Service Commission, Washington, D. C.; the Secretary of the United States Civil Service Board, Customhouse, Boston, Mass., New York, N. Y., New Orleans, La., Honolulu, Hawaii; Post Office, Philadelphia, Pa., Atlanta, Ga., Cincinnati, Ohio, Chicago, Ill., St. Paul, Minn., Seattle, Wash., San Francisco, Calif., Denver, Colo.; Old Customhouse, St. Louis, Mo.; Administration Building, Balboa Heights, Canal Zone; or to the Chairman of the Porto Rican Civil Service Commission, San Juan, P. R.

Applications should be properly executed, excluding the medical certificate, and must be filed with the Civil Service Commission, Washington, D. C., with the material required, prior to the hour of closing business on February 14, 1922.

The exact title of the examination, as given at the head of this announcement, should be stated in the application form.

Preference.—Applicants entitled to preference should attach to their applications their original discharge, or a photostat or certified copy thereof, or their original record of service, which will be returned after inspection.

Issued January 3, 1922.

Correspondence.

THE TRAINING OF NURSES AND ATTENDANTS.

J. W. Bartol, M. D., Chairman,
Committee on Legislation,
Massachusetts Medical Society,
Boston, Massachusetts.

Dear Doctor:

I have read with interest the article by you on Legislation as proposed by the Massachusetts Medical Society, and was quite interested in it, especially because of article 7. The Training of Nurses and Attendants. Perhaps my recent admission to the Massachusetts Medical Society would make me hesitate to write so soon on any subject, but inasmuch as I have been intimately connected with nursing situations for the last eight years, perhaps my experience and associations could answer some of the questions you put.

I believe I may say, with some modesty—that I am the only physician who serves the nursing association in this state as a member of its Directory for Nurses, and I have served in that capacity for the past three years; am a member of the Massachusetts State Nurses' Association, Massachusetts Private Duty Nurses' League, Director of the Male Nurses' Association of Massachusetts, and founded and conducted until my entry into service in 1918, a school for attendants in Cambridge, which has had approval and recognition. In these various capacities, I have come into close contact with the nursing problems.

The resolutions you refer to as passed at the New England Surgical Society, about fifteen months ago by Dr. Mayo (I presume you mean Dr. Charles Mayo), I have not read, so cannot discuss. But I have read with interest Dr. Charles Mayo's interview to the *Pictorial Review* in October, 1921, also the criticisms and answers to it, by the nurses, in the *American Journal of Nursing*, *The Trained Nurse and Hospital Review*, and the *Canadian Nurse and Hospital Review*,—many of the answers of which are well put.

Has the Board of Registration gone too far in its requirements?

No. It should demand even higher requirements if it is to keep pace with the recommendations of the American Medical Association, and other similar organizations for classification of hospitals, according to their facilities—clinical, laboratory, etc.

Is there any practical way in which the training of nurses can be graded according to the type of work which they intend to undertake?

This question is impossible to answer, unless we have a sworn statement from the pupil nurse, saying she will restrict her work to a prescribed course, and will also practice only after receiving her training to this extent. It is possible to demand such a statement, and we haven't any law which would permit this, or is it probable we could effect such legislation.

Is the training of attendants and their recognition by the state the answer to this problem?

No. While we can, and should train attendants, there is no present provision for the supervision of these attendants, and no proscription of what they may do; and even if we did effect legislation recognizing the training of attendants, who is to supervise their work after they finish their training, and can the state supervise? Certainly in the matter of salary or wages, the state cannot set any arbitrary amount,—this would be unconstitutional.

Will the training of attendants carry us back to the conditions existing in the early days of the training of nurses?

Yes, if we are to permit the promiscuous training of these attendants, in unofficial and improperly conducted schools, which may be of commercial character. Again, who will have supervision over these schools, and who shall classify them, and set their standards,—especially if they remain to be created? Who will investigate and eliminate the undesirables from this work, and how shall the profession of medicine be prevented from employing the undesirables? They exist today without authority to control them or supervise them.

If we can secure a simplification of the nurses' training without lowering professional standards, much will be accomplished. This last statement in your article, would indicate that the present system of training is complicated; somehow this would open up controversy, for if you would know the standards of each state, you will find a national standardization, which is quite simple and not too complex.

As to whether the Massachusetts Medical Society can assume any leadership in the matter, this might be answered by saying that the influence of such an organization can be helpful, if not dictatorial, and if cooperative; but surely on a basis of Dr. Charles Mayo's statements, and also Dr. William Mayo's statement, (Mayo Clinic, 1920), we of Massachusetts should be conservative, and hesitate in committing ourselves to some of his policies which are quite radical, and not easily applicable to present conditions, nor should we forget to remember that Massachusetts has contributed no small part to the pioneer movement of nursing in the United States, and that here may be found splendid leaders, well versed in the nursing problems, conservative and yet progressive, who would be only too glad to lend their knowledge to this movement. For though statements have been made to the contrary, nurses are not arbitrary or effecting a closed shop. The Massachusetts Medical Society might appoint a committee of its members to meet a committee from the Massachusetts State Nurses' Association, to co-operate in the solving of these problems; it would be a happy precedent.

Personally,—the whole gist of this problem is to secure attendants at lesser rate than graduate nurses for the poor,—as one experienced in training these women, I must admit, as others interested in train-

ing attendants, that though our motives of supervising are the best and most ethical, nevertheless, we cannot control the situation after we have trained them; they can and do charge prices equal to graduate nurses, who are skilled and, strange to say, they are paid these salaries. The question is who can control the salaries, of each group, and can the state legislate? Training and its standardization is of secondary importance, and might be controlled or supervised.

I would be glad to render any service I can in this matter, but I would advise a non-committal attitude at the present time as regards nursing matters until this subject is more completely discussed and considered. Perhaps the profession would hesitate to co-operate with the nursing organizations, fearing this might commit them to a recognition of the nursing organizations officially; but if we will progress, this must come eventually, and why not now?

Very sincerely yours,
DAVID H. GIBSON, M.D.

MEDICAL LEGISLATION.

Mr. Editor:

It is a well-known fact that even a worm will at last turn and defend itself and, by implication, also its fellow worms.

I was for a time one of the "alleged spokesmen" who (Dr. Nason of East Foxboro states) "do not oppose or feebly oppose" legislation hostile to Medical Interests in State and Nation.

Let me say in behalf of myself and of Worcester and of Bartol, of Winghamton, of Bowers, and of Gay (to go back no further), that it is the apathy of the general practitioner and not the "feeble" efforts of the spokesmen, that makes so difficult the stemming of hostile legislation and the furtherance of what seems to us desirable.

Let me inform him that while his "feeble spokesmen," day after day and week after week, for months at a time, present themselves at the State House on Beacon Hill, it is with the utmost difficulty that the majority of physicians throughout the state can be induced to cross the street to present to an individual legislator the views of the profession on a given subject.

That they will, as a rule, heed neither the requests of the Committee on State and National Legislation nor those of the member of the Auxiliary Committee who lives in their vicinity, and that a general appeal for help at home rouses to action but a small portion of the 3,600 members of the Massachusetts Medical Society. May I also state that our society is not a collection of plutocrats, as Dr. Nason implies; that it does include men with small as well as those with large incomes; that it has always tried to gather in all reputable physicians practising in the State and has largely succeeded in so doing; that as Chairman of the Committee on Membership I can state that increase in dues has not resulted in a falling off in membership and, finally, that as preparer of the budget, I would be pleased to know what features that "certain members wish to enjoy and others do not" he would have eliminated for, unless my committee is instructed, it cannot know how to proceed.

Mr. Editor: No game was ever won by those who stand on the side lines and kick. All kicking should be done in the field and at the ball. A united profession behind and in support of our legislative committee can do much to assist it to attain its ends.

SAMUEL B. WOODWARD, M.D.

REGISTRY OF BONE SARCOMA.

Mr. Editor:

I wonder if you would give me your help in obtaining some statistics for the Registry of Bone Sarcoma. It is desirable to know the frequency of occurrence of cases of this lesion and there are no statistics by which we can obtain it. It occurred to me that a pretty accurate estimate could be made in the following way:

According to the Directory of the American Medical Association the population of Massachusetts is 3,602,329 and the number of physicians is 3,494. If each one of these physicians should drop me a postal saying, either "I do know or I do not know of a case of bone sarcoma at present alive in Massachusetts," we should have almost by return mail the best information in the world on the percentage of this disease per capita of population.

Of course, I realize that your JOURNAL, interesting and instructive as it is, by no means reaches every physician in the state and that many of those whom it does reach do not read everything in it. Nevertheless, there seems to be a way to counterbalance that discrepancy. If every physician who *does* read this letter will constitute himself a local committee for a week and ask every other physician he meets during that week whether he knows of a living case of bone sarcoma, and obtains their signatures, I believe we should reach nearly every physician in the state. These could be checked off in the Directory and I could make a personal appeal to the remainder.

I believe that every doctor in Massachusetts would be glad to contribute his bit to medical science, if the doing so did not involve too much time and expense. This plan would involve but a minute of time and a cent apiece, so the main thing would be to get the plan to them. Will you try it? They will each do their bit if you do.

A few words about the Registry may not be out of place. The Registry of Bone Sarcoma aims to be a combined national study of the diagnosis and treatment of this lesion. Although organized independently by Dr. Bloodgood of Baltimore, Dr. Ewing of New York and the writer, it is now a Committee of the American College of Surgeons. Our object is to register every case of bone sarcoma and by following the cases (through their medical attendants) to learn what the result of each is and what, if any, forms of treatment are effective. At present, these cases are too rare for any one surgeon or clinic to obtain a sufficient number for study. We do not expect to find an excessive number in the whole country. In fact, during the year and a half in which we have been collecting cases, we have only found four five-year cures by amputation, and altogether only under one hundred cases which are now living, including those known to be moribund.

If the physicians of Massachusetts will promptly send in the postal cards, negative and positive, as above suggested, we shall at least know what the problem is in this state. All supposed-to-be bone sarcomas should be reported, including giant-cell tumors, except epulis. We want to know of all cases now alive whether cured, under treatment or moribund. We want negative answers as well as positive.

When we once know who has charge of each case in Massachusetts we can communicate directly with him and perhaps by showing our collection help him to treat his particular case more satisfactorily. We can, at least, give him expert pathologic opinion on sections of tissue. We should be glad to demonstrate our collection to anyone interested.

I hope, Mr. Editor, you may see fit to publish this letter, although I fully realize that it may be a precedent you do not care to establish. I ask the favor because our Committee represents a great na-

tional association which has undertaken this intensive study of a rare and singularly fatal disease. The work of the Committee consumes a great deal of time and I hope that you and your readers will help us out.

The American College of Surgeons holds its Clinical Congress in Boston next October. I hope we shall then be able to state the exact number of cases of bone sarcoma in Massachusetts, with pathologic proof of each case if it is obtainable.

Should this letter be read by physicians outside of Massachusetts, I may repeat that this investigation is a national one, and we should appreciate any positive reports of cases. It is only in Massachusetts that I am trying to get *negative* as well as positive replies.

Sincerely,

E. A. CODMAN, M.D.

[NOTE.—Here is an opportunity for the profession to contribute to this study of an important subject. Let everyone do his part and send in his postal card.—Editor.]

CONCERNING LEGISLATIVE PROTECTION.

Spencer, Massachusetts,

January 16, 1922.

Mr. Editor:—

It seems to me that we, as physicians, ought to take an active interest in defeating the plan of John N. Cole, Chairman of the Department of Public Works of Massachusetts, to increase motor registration fees and impose a tax on gasoline.

It is not that we are unwilling to bear our fair share of taxation, because we are willing to bear it, but that such a tax on gasoline, particularly for the purpose proposed, will be unfair to every physician in the state, for the country practitioner uses the state road probably less than 10% of his actual mileage, thus a tax of two cents per gallon on gasoline would mean that he would be paying a tax of twenty cents on each gallon he uses to travel on state roads. The rest of his travels are on country roads, usually poorly kept up. The city practitioner uses mostly the streets of his own town where he pays taxes, and to burden each gallon of gasoline he uses is obviously unfair.

Therefore we should all use our influence with our representatives and senators to oppose such a tax (and the same applies to the raising of registration fees to approximately double the present rate) and make our stand known in no uncertain manner.

Here, now, is a concrete example of the value to us of a Medical Legal Society. The present Legislative Committee would be reluctant to assume the leadership in a fight for the doctors' financial saving. The present committee might feel that its influence in the field of medical legislation would be weakened thereby, and with that I agree. But—and here is the point—we need an organization outside the Massachusetts Medical Society, state-wide in scope, having for its object the furthering of the material welfare and the protection of the material interests of its members. Its membership would be composed of all practitioners of the state who care to join. A legal department would be a prime essential. It would not be hampered by any of the traditions belonging to any existing organization but could begin on a new, progressive formula.

Dr. Hutton of Shelburne Falls, and Dr. Upton of the same city, have expressed themselves along this line, and I make the following as a concrete suggestion:

Let Dr. Hutton and Dr. Upton call a meeting of physicians, who can come to a central part of the state, say Worcester, for instance, and have those few draw up plans, simple and direct, for a Medical Legal Association, and offer that plan to the physicians of

the state by personal letter or through the columns of the JOURNAL.

Many who could not attend the original meeting would join and be glad of the chance to assist in the growth of the organization, and reap its benefits.

Wide expression of opinion is necessary and desirable. To those digging along in the old rut it will seem unnecessary, but shall the progressives be impeded in their progress by the inertia of the well-fixed, the satisfied, and the retrogressionists?

Sincerely yours,

J. R. FOWLER, M.D.

[NOTE.—The JOURNAL will open its columns for further expressions of opinion.—Editor.]

LEGISLATIVE MATTERS.

Shelburne, Falls, Mass.,
January 21, 1922.

Mr. Editor:

In your issue of January 19, appears a letter from Dr. Nason along similar lines to those of my letter of December 29. In your comment on this letter you say that "the other severe indictment of our alleged spokesmen is almost cruel and shows that our correspondent is not fully informed of the time and attention devoted to legislative matters by the President and other officers of the Society, etc." Now Mr. Editor, without wishing to enter into a wordy controversy with you, in which I am sure to get the worst of it as you will always have the last word, I will only call your attention to the fact that I did not intimate that our officers had not spent or did not spend time and effort in legislative matters connected with our professional work. What I did say, in effect, was that these same officers often did not represent the opinion and desires of the majority of our members and I still hold to that statement.

As an example, I will take the case of Ex-Pres. Worcester. It is granted that he spent a large amount of time and labor in drawing up and advocating the "Young Maternity Benefits" bill. But that bill was most bitterly opposed by a large majority of the profession in this State. He came to a meeting of the Franklin District Medical Society to advocate the passage of this bill and seemed much displeased when he found the majority opinion against him. From these facts I draw the conclusion that it should be the duty of our officers not to act as propagandists of any new piece of legislation, that is of vital interest to our members, until they first have ascertained by referendum or otherwise the feelings and desires of the majority of our members. Perhaps I am mistaken in my belief, but in a democracy the majority is supposed to rule and I, for one, do not choose to have my thinking done for me by any one, no matter how eminent a member of our profession he may be.

Very truly yours,

CHARLES L. UPTON, M.D.

NOTE.—It is pertinent to again make public the fact that the ex-president referred to tried to ascertain the attitude of members of the Society through a questionnaire asking for facts and opinions relating to the subject referred to by the correspondent. May it not promote harmony if we extend generous appreciation of sincerity even though we disagree on measures advocated.—Editor.

INTEREST IN COÖPERATIVE HEALTH PLANS FOR BOSTON.

A MOVEMENT has been inaugurated to place at the disposal of the Mayor of Boston and the Health Department, such assistance as may be

desired in formulating and executing plans designed to insure a model administration of health measures. There seems to be no disposition on the part of those interested to intrude or to dictate, but rather assure the Mayor that the medical profession is in sympathy with his avowed purpose to give the city every protection which may be expected from an efficient application of recognized methods. With this end in view conferences have been held with the Mayor, the details of which are set forth in the subjoined letters and resolutions:

Boston, Massachusetts,
January 19, 1922.

Hon. James M. Curley,
Mayor-Elect of the City of Boston.

Sir:—

As an introduction to the Resolution subjoined, the undersigned Committee has prepared the statement which follows:

The Committee does not wish to imply that a change in the Health Commissionership of the City of Boston is desirable, undesirable, necessary or unnecessary.

Should a change in the Health Commissionership become desirable or necessary the Committee wishes emphatically to state that it was appointed with the understanding that it would not attempt to further the candidacy or to support the claims for the Health Commissionership of any individual.

The Committee believes that it will have fulfilled its functions when it has conferred with you in regard to the principles endorsed by its constituents and has published for the information of the public a statement of its position and of the action taken.

Believing that you, as Mayor-Elect, appreciate the importance of health to the citizens of Boston, and the great responsibility resting upon you, and upon you alone, in the selection of a new Health Commissioner,—if, indeed, circumstances should render such a change desirable or necessary,—and assuming that you realize the rapid development which is taking place in methods for the prevention of disease and for the administration of affairs pertaining to the health of the public, the undersigned Committee desires in all modesty and sincerity to direct your attention to the fact that with the developments above mentioned has come to members of the medical profession an increasing sense of their responsibility to the public in matters pertaining to the prevention of disease and a realization that it is incumbent upon the medical profession to offer any assistance which may be in its power for the furtherance of the interests of the public in matters pertaining to health.

(Signed)

GEORGE C. SHATTUCK, Chairman.
HORACE D. ARNOLD.
WILLIAM H. WATTERS,
MILTON J. ROSENAU,
HORACE MORISON.

Boston, Massachusetts,
January 19, 1922.

Hon. James M. Curley,
Mayor-Elect of the City of Boston.

Sir:—

The undersigned Committee begs leave respectfully to present to you a Resolution which was adopted at a meeting of delegates of medical and of other organizations interested in public health and preventive medicine in the City of Boston. The meeting was held on January 11th, at 8 P.M., in the Boston Medical Library.

The Resolution was unanimously adopted by the

delegates, acting as individuals, and with the understanding that it should be sent to their respective organizations for official consideration.

The delegates present at the meeting represented the following organizations:

American Red Cross (Boston Metropolitan Chapter)
Baby Hygiene Association
Boston Health League
Boston Lying-in Hospital
Boston Tuberculosis Association
Boston University School of Medicine
Children's Hospital
Faculty of the Harvard University Medical School
John Hancock Mutual Life Insurance Company
Instructive District Nursing Association
Massachusetts Charitable Eye and Ear Infirmary
Massachusetts General Hospital
Massachusetts Homeopathic Hospital
Norfolk District Medical Society
Peter Bent Brigham Hospital
St. Elizabeth's Hospital
Suffolk District Medical Society

The resolution adopted at the meeting is as follows:

"Resolution Passed at a Meeting Called by the Committee on Public Health of the Suffolk District Medical Society on January 11, 1922.

Whereas we believe that maintenance of health and the prevention of disease is of vital interest to all citizens of Boston, and

Whereas the function of the Department of Health in the prevention of disease and the preservation of health is expanding in importance and should continue so to expand, and

Whereas the citizens must inevitably pay the penalty in health and in life if their Department of Health should fail to maintain the highest efficiency, and

Whereas it is rumored that the Commissionership of Health for the City of Boston may soon become vacant.

Be it therefore resolved:—

Firstly: that the Commissionership of Health is an office of the very greatest importance to the welfare of the citizens of Boston.

Secondly: that the Commissionership of Health should at all times be held by a specially trained and qualified man.

Thirdly: that the most essential qualifications for the Commissionership of Health are high character, special educational training for health work, experience in public health work, and qualities of leadership with administrative capacity.

Fourthly: that in order to make the Commissionership of Health a position that will at all times attract the best men, it is essential to maintain the principle that tenure of office is dependent not on political considerations, but on character of service alone.

Fifthly: that the organized bodies voting the above resolutions should offer to the Mayor-Elect all possible support in giving effect to the said resolution."

After adoption of the resolution it was voted that the Chair appoint a committee of five with power, who should coördinate the official endorsements of the resolution, present the resolution to the Mayor-Elect, and perform other functions deemed by it necessary on behalf of its constituents.

The Committee has sent the Resolution not only to the organizations represented at the meeting, but also to many other bodies which it was thought might be interested in the movement. Several of these bodies have already endorsed the Resolution.

The time elapsed since January 11th being short, many organizations have been unable as yet to take official action, but members of the Committee have received assurances that a number of these bodies approve the principles set forth in the Resolution and that their hearty support will be evinced in due time officially.

Endorsements are expected not only from most of the organizations which sent delegates to the meeting, but from a further considerable number of interested bodies.

Respectfully submitted by the Coördinating Committee.

(Signed)

GEORGE C. SHATTUCK, *Chairman*.

HORACE D. ARNOLD,

WILLIAM H. WATTERS,

MILTON J. ROSENAU,

HORACE MORISON.

(Endorsements Appended.)

ENDORSEMENTS.

1. Prof. C. M. Hilliard, Chairman of the Health Service Committee of the Boston Metropolitan Chapter of the Red Cross.

2. Dr. Richard M. Smith, for the Baby Hygiene Association, with the sanction of a majority of the Board of Trustees.

3. Executive Committee of the Boston Lying-in Hospital.

4. Executive Committee of the Boston University School of Medicine.

5. Executive Committee of the Staff of the Peter Bent Brigham Hospital.

6. Board of Managers of the Instructive District Nursing Association.

7. Household Nursing Association, Incorporated, and Training School for Attendants.

8. Massachusetts Society for Social Hygiene.

9. General Executive Committee of the Staff of the Massachusetts Homeopathic Hospital.

10. Boston District of the Massachusetts Homeopathic Society.

11. Dr. William R. P. Emerson, President, on behalf of the Nutrition Clinics for Delicate Children.

12. General Executive Committee of the Ophthalmic and Aural Staffs of the Massachusetts Charitable Eye and Ear Infirmary.

In addition to the endorsements of the Resolution, the attached letter has been received from Mr. Kelso, Executive Secretary of the Boston Council of Social Agencies. This organization includes about 178 Social Agencies.

Boston Council of Social Agencies.

January 17, 1922.

Mr. Horace Morison,
Boston Health League,
163 Meridian Street,
East Boston, Mass.

Dear Mr. Morison:

In the matter of the resolutions which the Coördinating Committee of the Suffolk District Medical Society contemplates presenting to His Honor, the Mayor, there is likely not a dissenting voice in the entire group of social agencies involved in this Council against these proposals. The Boston Council, as such, being organized not for the purpose of expressing its opinion, or of supporting definite proposals, is not as a matter of basic policy in a position to give formal endorsement to the resolutions.

Personally, I know how well received this statement would be by all our agencies, and I know that His Honor, the Mayor, who has always sympathized with the social service work which this group is rendering, would understand how much they desire the highest possible degree of skill at the head of the public health administration of the city.

Very truly yours,

(Sgd) ROBERT W. KELSO,
Executive Secretary.

A second letter of especial importance, received

from Dr. Robert B. Osgood, Chairman of the Executive Committee of the Boston Health League, is appended:

Boston Health League,
163 Meridian St., East Boston.

January 19, 1922.

Dr. George Cheever Shattuck,
Chairman of the Co-ordinating Committee,
205 Beacon St., Boston, Mass.

My dear Dr. Shattuck:

In regard to the resolutions that were adopted at a meeting of the representatives of the medical and other organizations, held January 11th, 1922, and which it is desired to present to His Honor, the Mayor-Elect, these resolutions have been referred to the various member agencies of the League. At this time a number of the agencies have already signified their approval.

An expression of opinion in a matter of this kind should come from the agencies themselves rather than from the Council or Executive Committee of the League. I am confident that the group of health and other agencies in the League will be anxious to ratify the resolutions as soon as it is possible for their committees or boards to meet, and for myself and other members of the Executive Committee, as individuals, I am only glad of the opportunity of sending you my hearty endorsement.

Very truly yours,

(Sgd) ROBERT B. OSGOOD,
Chairman Executive Committee.

Copy of letter sent to the following newspapers, Thursday evening, January 19, 1922:

Boston Advertiser, Christian Science Monitor, Boston Telegram, Boston American, Boston Herald, Boston Transcript, Boston Jewish American, Boston Globe, Boston Post, Boston Traveler.

To the City Editor.

Sir:

At a conference with Mr. James M. Curley, held this afternoon, the foregoing documents were presented to him and are hereby offered to you for publication with the sanction of Mr. Curley and of the Committee which has signed the papers.

Very truly yours,

(Sgd) GEORGE C. SHATTUCK,
Chairman of Co-ordinating Committee.

NOTICES.

THE SPRINGFIELD ACADEMY OF MEDICINE.—On the evening of March 7, 1922, at the Central High School Hall a public meeting, under the auspices of the Academy, will be held for the purpose of emphasizing to the laity the sound, scientific basis on which the practice of medicine rests. The speaker will be Dr. Ernest LaPlace, Professor of Clinical Surgery at the University of Pennsylvania, and a graduate of the University of Paris. He has chosen for the subject of his address, "Louis Pasteur," whose pupil he was for many years.

Members are urged to report interesting cases more frequently.

The Academy wishes to enlarge its membership. Will members please see that every eligible physician receives and signs an application blank?

The January meeting of the Springfield Academy of Medicine was held Tuesday, January 10, with Dr. Hugh Auchincloss of New York City as speaker. Dr. Auchincloss read a paper entitled "Surgery of the Hand." Luncheon was served after the meeting.

ALLEN G. RICE, Secretary.

CHILDREN'S HOSPITAL.—Clinical Meetings of the Staff of the Boston Children's Hospital will be held in the amphitheatre once a month from November to May inclusive. The meetings will be held on Friday afternoons at 4.30 P.M. All members of the profession are cordially invited to be present. The dates of the meetings are November 4th, December 9th, January 13th, February 10th, March 10th, April 14th, and May 12th.

THE NEW ENGLAND PEDIATRIC SOCIETY.

The seventy-second meeting of the New England Pediatric Society will be held at the Boston Medical Library on Friday, February 10, 1922, at 8.15 P.M.

The following papers will be read:

1. President's Address.
Richard M. Smith, M.D., Boston, Mass.
2. Is there More than One Kind of Rickets?
Edwards A. Park, M.D., New Haven, Conn.
(Discussed by F. R. Ober, M.D., Boston.)
3. The Experimental Feeding of a Vitamin-Deficient Diet, with Especial Reference to Scurvy.
L. W. Smith, M.D., Boston.

Light refreshments will be served after the meeting.

RECENT DEATHS.

DR. J. MACDONALD, JR., of the Surgery Publishing Co., died on Saturday, January 7th, 1922.

THE American Association of Anaesthetists and the Mid-Western Association of Anaesthetists will hold a joint meeting in St. Louis, May 23-24, at Hotel Jefferson, the first three days of the A.M.A. week.

LEGAL HEARINGS.

BEFORE COMMITTEE ON PUBLIC HEALTH.

February 6—On Vaccination.

February 8—House bill 423. Petition for registration of midwives.

February 8—House bill 600. Petition relative to the sale of hypodermic syringes and needles.

February 8—Relating to the Appointment of Members of the Board of Registration in Medicine, and the bill for the Limited Practice of Medicine.

February 13—Bills relating to the use of narcotic drugs.

February 13—House 749. Petition of Janet MacAdam, relative to the waiver of education requirements for certain applications for registrations as chiropractors.

February 13—House 956. Petition of S. H. Wragg, for further restrictions of the use of habit-forming drugs.

February 13—Senate 140. Establishing the Division of Registration and Narcotic Drug Control.

February 14—House 588. Relative to commitment of insane or feeble-minded.

RESEARCH CLUB OF HARVARD MEDICAL SCHOOL.—At the meeting to be held on Friday, February 3rd, in the Amphitheatre in Building A, at 12.30 o'clock, Dr. Alexander Forbes will talk on "Modern Views of Nerve Physiology."